Immunization Form for College Students

In accordance with the Rhode Island Department of Health's Rules and Regulations Pertaining to Immunizations and Testing for Communicable Diseases for Students Entering Colleges or Universities (R23-1-IMM/COL), the following student populations must complete and return this form.

- All incoming full-time students must complete section A and have section B completed and signed by a licensed health care provider with the exception of high school records or VA records. Students in a health care field of study should refer to immunization forms provided by their department.
- NOTE: Titers are available through East Side Lab for a discounted rate. You must contact CCRI's Health Services nurse for a lab slip at 401-825-2103.

Part A: Personal Student Information:

Date: _____ CCRI ID*: _____

Student's name: _____ Date of birth: _____
Last, First, MI MM/DD/YY

Telephone number: _____ Email address: _____

Program of study: _____ Part time ☐ Full time ☐ Campus: _____

*A Social Security number also can be used but a CCRI ID is preferred. Don't know your CCRI ID number? It can be found printed on a bill or a class schedule, in your MYCCRI account, or by contacting Enrollment Services.

Part B: Immunization Information – All information is REQUIRED.
Please note that students carrying less than 12 credits do not need to submit this form.
Any student who cannot access childhood records can have titers done at a discounted rate.
Please contact the CCRI nurse for more information.

							Was titer done? Acceptable in place of vaccine dates if unable to obtain immunization records.
MMR	1st dose	_____ MM/DD/YY	2nd dose	_____ MM/DD/YY			☐ Attach lab work
Hepatitis B	1st dose	_____ MM/DD/YY	2nd dose	_____ MM/DD/YY	3rd dose	_____ MM/DD/YY	☐ Attach lab work
OR HEP B (Heplisav)	1st dose	_____ MM/DD/YY	2nd dose	_____ MM/DD/YY			☐ Attach lab work
Varicella (Chicken Pox)	1st dose	_____ MM/DD/YY	2nd dose	_____ MM/DD/YY			☐ Attach lab work
Covid-19	1st dose	_____ MM/DD/YY	2nd dose	_____ MM/DD/YY	Booster #1:	_____ MM/DD/YY	
Email a copy of your COVID-19 vaccination record along with a copy of your Student ID to contacttracing@CCRI.edu.							
Tdap	Date:	_____ MM/DD/YY					
Meningitis	1st dose	_____ MM/DD/YY	Strongly recommended Under age 22		2nd dose	_____ MM/DD/YY	
Meningitis B	1st dose	_____ MM/DD/YY	Strongly recommended under age 22.		2nd dose	_____ MM/DD/YY	If 1st dose given prior to age 16.

Health Care Provider signature _____ Date: _____
Telephone _____

Please note that if you have graduated from a Rhode Island high school within the past five years, you should be able to obtain a copy of your immunizations from that high school.

Please return all forms to:
CCRI Health Services, KN1240
400 East Ave. Warwick, RI 02886
PHONE (401) 825-2103
FAX (401) 825-1077 nurse@ccri.edu

Revised: 2018, 2021, 2022