Immunization Form for Health Science Students

In accordance with the Rhode Island Department of Health R*ules and Regulations Pertaining to Immunization, Testing, and Health Screening for Health Care Workers.* **(R23-17-HCW)**, the following student populations must complete and return this form.

For more information about the Immunization requirements visit http://www.ccri.edu/OES/immunization.shtml

- **All incoming students enrolled in one of the programs listed below must complete section A and then have sections B and C completed and signed by a licensed health care provider.**

- Clinical Laboratory Technology
- Dental Assisting
- Dental Hygiene
- Diagnostic Medical Sonography
- *Emergency Disaster Management
- Fire Science (EMT)
- Histotechnician
- Health Care Interpreter
- Magnetic Resonance Imaging
- Nursing
- Occupational Therapy Assistant
- Opticianry Program
- Phlebotomy
- Physical Therapist Assistant
- Respiratory
- Radiography
- Renal Dialysis Technology
- Therapeutic Massage

**Follow General College Requirements*

Part A: Personal and Student Information

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

Date: _____ CCRI ID: _____

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

Phone number: _____ CCRI e-mail Address: _____

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

Part B: PPD and Color Blind Testing

Initial entry into program requires two negative PPD tests†, no less than two weeks apart and no more than six months apart. Then one test is required annually.

PPD Testing

Ist Test: _____ _____ ☐ Negative ☐ Positive Reading Value_____mm
Planted Read

2nd Test: _____ _____ ☐ Negative ☐ Positive Reading Value_____mm
Planted Read

†**Students with a history of positive PPD test MUST:**

- Provide proof of negative chest x-ray taken after an initial positive test result.
- Have a health care provider complete and submit the Tuberculosis Symptom Assessment form.

Color Blind Test ☐ Fail ☐ Pass

Revised: December 2010

Part C: Immunization Information: Mandatory Titers (Must attach lab work)

Measles/ Rubeola	Titer Date:_____ _____ Immune _____ Not immune	**Not immune: Vaccine required** Date Vaccine: _____	Re-Titer 1-2 months: Titer Date:_____	
Rubella	Titer Date:_____ _____ Immune _____ Not immune	**Not immune: Vaccine required** Date Vaccine: _____	Re-Titer 1-2 months: Titer Date:_____	
Mumps	Titer Date:_____ _____ Immune _____ Not immune	**Not immune: Vaccine required** Date Vaccine: _____	Re-Titer 1-2 months: Titer Date:_____	
Varicella (Chicken Pox)	Titer Date:_____ _____ Immune _____ Not immune	**Not immune: Vaccine required** Date: 1st Vaccine_____ Date: 2nd Vaccine_____	Re-Titer 1-2 months: Titer Date:_____	
Hepatitis B	**Skip to next block if you have already had the 3 doses** 1st Dose_____ 2nd Dose_____ *One month from first shot* 3rd Dose _____ *Six months from first shot* **Titer required in one to two months**	Titer Date:_____ *(Only if you already have had 3 doses)* _____ Immune _____ Not Immune	Booster Series Required Date:_____ Date:_____ Date:_____	Re-Titer 1-2 months: Titer Date:_____
Tdap	**Date:**_____ ‡Tdap replaces the Td for health care providers. Td = Tetanus and Diphtheria; Tdap = Tetanus, Diphtheria and Pertussis. If your Tetanus is older than two years, Tdap is required. Tdap is good for 10 years.			
Flu Vaccine	**Strongly recommended, not required *(annually)***			

Medical Exam: I hereby certify that this student is in good health and able to participate in all clinical activities without limitations. **(Provider: Please initial.)** _____

Health care provider signature: _____ **Date:**_____

Provider printed name: _____ **Phone:** _____

In an effort to ensure that all records are processed in a complete and efficient manner, we ask that all information be provided on this form ONLY, with any required lab results attached, and that they be submitted in a timely manner.

Mail, fax or bring forms to: **CCRI – Health Services, Room 1240**
Angela Marshall, RN
400 East Ave.
Warwick, RI 02886
Fax: 401- 825-1077

Note: Any student exempt from immunizations for medical or religious reasons must complete a certificate of exemption form, which is available through his or her physician's office or CCRI's Health Services Office, located on the Warwick campus. The completed form should be forwarded along with all other health information.