College ID# _____

Student Cell Phone # *(required)* _____

UNIVERSITY OF RHODE ISLAND
DR. PAULINE B. WOOD HEALTH SERVICES
Health Information Management Department
6 Butterfield Road • Kingston, RI 02881
401-874-4612 • FAX 401-874-5772

DUE DATE
1st Day of Classes

IMMUNIZATION RECORD

THIS SIDE MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER.

STUDENTS WHO FAIL TO PROVIDE THE REQUIRED CERTIFICATE WILL NOT BE PERMITTED TO REGISTER

NO SHOT – NO CLASS!!

Student Name: _____ **Date of Birth:** _____
(Please print) Last Name First Name MI

Social Security # xxx-xx- ____ ____ ____ ____ **M** _____ **F** _____

MANDATORY

- **MEASLES, MUMPS, RUBELLA (MMR):** Two doses of MMR are required *or* positive immune titer verifying immunity.

  MMR Dose 1 ____/____/____ Dose 2 ____/____/____ **OR** Positive Titer ____/____/____

- **HEPATITIS B:** Requirement: Three doses (doses one and two given four weeks apart and the third dose should be at least four to six months after first dose) ***or*** positive immune titer verifying immunity.

  Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____ **OR** Positive Titer ____/____/____

- **TETANUS:** Requirement: Tetanus must be administered within the past 10 years.

  TD ____/____/____ **OR** Tdap ____/____/____

- **VARICELLA:** Requirement: Two doses of chicken pox vaccine are required at least one month apart (one dose is sufficient if given before age 13) ***or*** positive immune titer verifying immunity ***or*** medical provider's documented history of disease.

  Dose 1 ____/____/____ Dose 2 ____/____/____ **OR** Positive titer ____/____/____ **OR** Disease History ____/____/____

- **TUBERCULOSIS:** * **See Tuberculosis Screening Form** (enclosed).

RECOMMENDED

- **VARICELLA:** Dose 2 ____/____/____ Strongly recommended, even if Dose 1 given before Age 13
- **MENINGOCOCCAL VACCINE:** (Groups A, C, Y and W-135) Last Dose ____/____/____
  Strongly recommended, especially for freshmen living in residence halls.
  * If you were vaccinated prior to your 16th birthday, a booster dose is recommended unless you are 21 years of age or older.
- **SEASONAL FLU:** ____/____/____
- **HEPATITIS A:** Immunization (Hepatitis A) Dose 1 ____/____/____ Dose 2 ____/____/____
- **HUMAN PAPILLOMAVIRUS VACCINE (HPV):**
  (Three doses of vaccine for female college students 11-26 years of age at 0, 2, and 6 month intervals.)

  Immunization (HPV) Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____

OTHER

STUDENTS WHO FAIL TO PROVIDE THE REQUIRED CERTIFICATE WILL NOT BE PERMITTED TO REGISTER.

_____

_____

_____

_____

Health Care Provider: _____ **Date:** _____
(Please print)

Signature and Title: _____ **Office Phone:** _____