



Immunization Form for College Students

In accordance with the Rhode Island Department of Health 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 in any program of study, as well as any full- or part-time student entering CCRI on a student or other Visa, must complete section A and have section B completed and signed by a licensed healthcare provider. Students in a health care field of study should refer to immunization forms provided by their department.**

Part A: Personal and Student Information

Date: _____ CCRI ID*: _____

Student's Name: _____ Date of Birth: _____
Last, First, MI MM/DD/YY

Phone Number: _____ E-mail Address: _____

Program of Study: _____ Part-time Full-time Campus: _____

* 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.

Part B: Immunization Information – All information is REQUIRED. DO NOT OVERLOOK THE CHICKEN POX REQUIREMENT!

- **NOTE: Titers are available through East Side Lab for a discounted rate. You must contact CCRI Health Services Nurse for a Lab Slip.**

Was Titer done?
 Acceptable in place of vaccine dates if unable to obtain immunization records.

Measles	First Dose Date: _____ <small>MM/DD/YY</small>	Second Dose Date: _____ <small>MM/DD/YY</small>	<input type="checkbox"/> Attach lab work	
Rubella	Date: _____ <small>MM/DD/YY</small>		<input type="checkbox"/> Attach lab work	
Mumps	Date: _____ <small>MM/DD/YY</small>		<input type="checkbox"/> Attach lab work	
Hepatitis B	1st Date: _____ <small>MM/DD/YY</small>	2nd Date: _____ <small>MM/DD/YY</small>	3rd Date: _____ <small>MM/DD/YY</small>	<input type="checkbox"/> Attach lab work
Varicella (Chicken Pox)	1st Date: _____ <small>MM/DD/YY</small>	2nd Date: _____ <small>MM/DD/YY</small>	Or Hx Disease?	<input type="checkbox"/> Attach lab work
Td or Tdap Booster** (Circle one)	Date: _____ <small>MM/DD/YY</small> **Within the last 10 years.			

Health Care Provider Signature _____ Date _____

Phone _____

Please return all forms to:
CCRI Health Services, Room 1240
Angela Marshall, RN
400 East Ave.
Warwick, RI 02886
Fax (401) 825-1077

Please note that if you have graduated from a RI high school within the past 5 years you should be able to obtain a copy of your immunizations from that high school.