



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 health care 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: _____ Last, First, MI	Date of birth: _____ MM/DD/YY
Phone number: _____	E-mail address: _____
Program of study: _____	Part time <input type="checkbox"/> Full time <input type="checkbox"/> 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 Pipeline account, or by contacting Enrollment Services.

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

Was Titer done? Acceptable in place of vaccine dates if unable to obtain immunization records.
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Measles	First Dose Date: _____ MM/DD/YY	Second dose Date: _____ MM/DD/YY	<input type="checkbox"/>	Attach lab work	
Rubella	Date: _____ MM/DD/YY		<input type="checkbox"/>	Attach lab work	
Mumps	Date: _____ MM/DD/YY		<input type="checkbox"/>	Attach lab work	
Hepatitis B	1st Date: _____ MM/DD/YY	2nd Date: _____ MM/DD/YY	3rd Date: _____ MM/DD/YY	<input type="checkbox"/>	Attach lab work
Varicella (Chicken Pox)	1st Date: _____ MM/DD/YY	2nd Date: _____ If #1 given after age 13 MM/DD/YY	Or Hx Disease?	<input type="checkbox"/>	Attach lab work
Td or Tdap Booster**	Date: _____ **Within the last 10 years. MM/DD/YY				

Health care provider signature _____
Phone _____

Return all forms to:
CCRI Health Services, Room 1240
400 East Ave, Warwick, RI 02886