



Immunization Form for Health Science Students

In accordance with the Rhode Island Department of Health Rules 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 healthcare 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 <input type="checkbox"/>	Full-time <input type="checkbox"/>	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 6 months apart. Then one test is required annually.

PPD Testing			
1st Test:	_____	_____	_____
	Planted	Read	<input type="checkbox"/> Negative <input type="checkbox"/> Positive Reading Value _____ mm
2nd Test:	_____	_____	_____
	Planted	Read	<input type="checkbox"/> Negative <input type="checkbox"/> Positive Reading Value _____ mm
† Students with a history of positive PPD test MUST:			
<ul style="list-style-type: none"> • 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	<input type="checkbox"/> Fail	<input type="checkbox"/> Pass	

Part C: Immunization Information: Mandatory Titers (Must Attach Lab Work)

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

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: 1 st Vaccine _____ Date: 2 nd Vaccine _____ ➡	Re-Titer 1-2 months: _____ Titer Date: _____
Hepatitis B	Skip to next block if you have already had the 3 doses ➡ 1 st Dose _____ 2 nd Dose _____ <i>One month from first shot</i> 3 rd Dose _____ <i>Six months from first shot</i> Titer required in one to two months	Titer Date: _____ <i>(Only if you already have had 3 doses)</i> ____ Immune ____ Not Immune ➡	Booster Series Required Date: _____ Date: _____ ➡ Date: _____ Re-Titer 1-2 months: Titer Date: _____
Tdap	Date: _____ ‡Tdap replaces the Td for healthcare providers. Td = Tetanus & Diphtheria; Tdap = Tetanus Diphtheria & Pertussis. If your Tetanus is older than two years, Tdap is required. Tdap is good for 10 years.		
Flu Vaccine	Strongly Recommend, 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 your physician's office or the Health Services Office, located on the Warwick campus. The completed form should be forwarded along with all other health information.