



# Immunization Form for College Students

In accordance with the Rhode Island Department of Health's 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 must complete section A and have section B completed and signed by a licensed health care provider with the exception of high school records or VA records. Students in a health care field of study should refer to immunization forms provided by their department.
- NOTE: Titers are available through East Side Lab for a discounted rate. You must contact CCRI's Health Services nurse for a lab slip at 401-825-2103.

## Part A: Personal Student Information:

Date: \_\_\_\_\_ CCRI ID\*: \_\_\_\_\_

Student's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Last, First, MI MM/DD/YY

Telephone number: \_\_\_\_\_ Email address: \_\_\_\_\_

Program of study: \_\_\_\_\_ Part time  Full time  Campus: \_\_\_\_\_

\*A Social Security number also can be used but a CCRI ID is preferred. Don't know your CCRI ID number? It can be found 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.

Please note that students carrying less than 12 credits do not need to submit this form. Any student who cannot access childhood records can have titers done at a discounted rate. Please contact the CCRI nurse for more information.

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

<b>MMR</b>	1 <sup>st</sup> dose	_____ MM/DD/YY	2 <sup>nd</sup> dose	_____ MM/DD/YY		<input type="checkbox"/> Attach lab work	
<b>Hepatitis B</b>	1 <sup>st</sup> dose	_____ MM/DD/YY	2 <sup>nd</sup> dose	_____ MM/DD/YY	3 <sup>rd</sup> dose	_____ MM/DD/YY	<input type="checkbox"/> Attach lab work
<b>OR HEP B (HepB)</b>	1 <sup>st</sup> dose	_____ MM/DD/YY	2 <sup>nd</sup> dose	_____ MM/DD/YY			<input type="checkbox"/> Attach lab work
<b>Varicella (Chicken Pox)</b>	1 <sup>st</sup> dose	_____ MM/DD/YY	2 <sup>nd</sup> dose	_____ MM/DD/YY			<input type="checkbox"/> Attach lab work
<b>Covid-19</b>	1 <sup>st</sup> dose	_____ MM/DD/YY	2 <sup>nd</sup> dose	_____ MM/DD/YY	Booster #1:	_____ MM/DD/YY	
<b>Tdap</b>	Date:	_____ MM/DD/YY					

**Meningitis** 1<sup>st</sup> dose \_\_\_\_\_ Strongly recommended Under age 22 2<sup>nd</sup> dose \_\_\_\_\_ MM/DD/YY

**Meningitis B** 1<sup>st</sup> dose \_\_\_\_\_ Strongly recommended under age 22. 2<sup>nd</sup> dose \_\_\_\_\_ MM/DD/YY If 1<sup>st</sup> dose given prior to age 16.

Health Care Provider signature \_\_\_\_\_ Date: \_\_\_\_\_  
Telephone \_\_\_\_\_

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

Please return all forms to:  
CCRI Health Services, KN1240  
400 East Ave. Warwick, RI 02886  
PHONE (401) 825-2103  
FAX (401) 825-1077 [nurse@ccri.edu](mailto:nurse@ccri.edu)