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. 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.
MMR	1st dose	_________ MM/DD/YY	2nd dose	_________ MM/DD/YY			☐ Attach lab work
Hepatitis B	1st dose	_________ MM/DD/YY	2nd dose	_________ MM/DD/YY	3rd dose	_________ MM/DD/YY	☐ Attach lab work
Varicella (Chicken Pox)	1st dose	_________ MM/DD/YY	2nd dose	_________ MM/DD/YY			☐ Attach lab work
Tdap	Date:	_________ MM/DD/YY					

Meningitis	1st dose	_________ MM/DD/YY	Strongly recommended under age 22.	2nd dose	_________ MM/DD/YY	If 1st dose given prior to age 16.
Meningitis B	1st dose	_________ MM/DD/YY	Strongly recommended under age 22.	2nd dose	_________ MM/DD/YY	If 1st dose given prior to age 16.

Health Care Provider signature _____________________ Date: __________

Telephone ______________________

Please return all forms to:
CCRI Health Services, Room 1240
Angela Marshall, RN
400 East Avenue
Warwick, RI 02886
(401) 825-2103
FAX (401) 825-1077
nurse@ccri.edu

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.

If you are a student veteran, you may be able to obtain your records from the VA.

Revised: February 2020