

New England Institute of Technology – STUDENT IMMUNIZATION FORM

THIS FORM MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER, OR YOU CAN SUBMIT A SIGNED IMMUNIZATION RECORD FROM YOUR PRIMARY CARE PROVIDER. **RETURN COMPLETED FORM TO YOUR ADMISSION'S OFFICER.**

Name of Student: _____ Date of Birth: _____

Resident student Non-resident student

In accordance with the Rhode Island Department of Health, the following immunizations are required of all entering full-time students. Students who fail to provide proof of the required immunizations will not be permitted to attend class or move into the residence hall until the requirements are met. All fees for service are the responsibility of the student.

THE FOLLOWING VACCINES ARE REQUIRED, INCLUDING DATES OF IMMUNIZATIONS, OR POSITIVE TITER.

VACCINE	DATES				TITER DATE	TITER RESULTS
Tdap (1 dose)	___/___/___					
MMR (2 doses)	___/___/___	___/___/___		OR	___/___/___	
Hepatitis B (3 doses)	___/___/___	___/___/___	___/___/___	OR	___/___/___	
Varicella (2 doses)	___/___/___	___/___/___	<i>Or date of disease:</i> ___/___/___	OR	___/___/___	
Meningococcal Vaccine (required for residential students under the age of 22)	___/___/___					

TUBERCULOSIS: COMPLETE THE "TUBERCULOSIS (TB) RISK ASSESSMENT" ON THE REVERSE SIDE OF THIS FORM. **IF YOU ANSWER YES TO ANY OF THE QUESTIONS, YOU ARE REQUIRED TO HAVE TB TESTING AND PROVIDE DOCUMENTATION OF THE TESTING** PRIOR TO THE START OF CLASSES OR MOVING INTO THE RESIDENCE HALL.

LOW RISK. PPD not required. **HIGH RISK.** PPD required.

IGRA/QUANTIFERON RESULT: _____ Date _____ **BCG VACCINE:** _____ Date _____

PPD (Mantoux)

Date Planted	Date Read	Results (mm)		Chest X-ray (if PPD positive)
___/___/___	___/___/___			Date:
___/___/___	___/___/___			Results:
___/___/___	___/___/___			Treatments:

FOR VETERINARY TECHNOLOGY ONLY:

<p>Pre-exposure Schedule for Rabies Vaccination* (Attach documentation) – Date of Injections:</p> <p>1st Dose (as appropriate) ___/___/___</p> <p>2nd Dose (7 days after Dose 1) ___/___/___</p> <p>3rd Dose (21 days after Dose 1) ___/___/___</p>	<p>Previous Dates of Rabies Series* (Attach documentation) – Date of Injections:</p> <p>1st Dose ___/___/___</p> <p>2nd Dose ___/___/___</p> <p>3rd Dose ___/___/___</p>	<p>Date of Rabies Current Titer* (Attach lab report documentation)</p> <p style="text-align: center;">___/___/___</p> <p>Result: _____</p>
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* If the primary rabies vaccine series was administered more than two years ago, or if the last rabies titer is more than two years old, then a current rabies titer is required.

HEALTH CARE PROVIDER INFORMATION:

Name (print): _____ Phone: _____

Address: _____

Signature: _____ Date: _____

Name of Student: _____ Date of Birth: _____

TUBERCULOSIS (TB) RISK ASSESSMENT (to be completed by student)

Please answer the following questions:

1. Have you ever had close contact with persons known or suspected to have active TB disease? Yes No

2. Were you born in one of the countries or territories listed below that have a high incidence of active TB disease (if yes, please CIRCLE below)? Yes No

Afghanistan	Central African	Gambia	Libya	Pakistan	Sri Lanka
Algeria	Republic	Georgia	Lithuania	Palau	Sudan
Angola	Chad	Ghana	Madagascar	Panama	Suriname
Anguilla	China	Greenland	Malawi	Papua New Guinea	Swaziland
Argentina	China, Hong Kong	Guam	Malaysia	Paraguay	Tajikistan
Armenia	SAR	Guatemala	Maldives	Peru	Thailand
Azerbaijan	China, Macao SAR	Guinea	Mali	Philippines	Timor-Leste
Bangladesh	Colombia	Guinea-Bissau	Marshall Islands	Poland	Togo
Belarus	Comoros	Guyana	Mauritania	Portugal	Trinidad and Tobago
Belize	Congo	Haiti	Mauritius	Qatar	Tunisia
Benin	Côte d'Ivoire	Honduras	Mexico	Republic of Korea	Turkmenistan
Bhutan	Democratic People's	India	Micronesia	Republic of Moldova	Tuvalu
Bolivia (Plurinational	Republic of Korea	Indonesia	(Federated States	Romania	Uganda
State of)	Democratic	Iran (Islamic	of)	Russian Federation	Ukraine
Bosnia and	Republic of the	Republic of)	Mongolia	Rwanda	United Republic of
Herzegovina	Congo	Iraq	Montenegro	Saint Vincent and	Tanzania
Botswana	Djibouti	Kazakhstan	Morocco	the Grenadines	Uruguay
Brazil	Dominican Republic	Kenya	Mozambique	Sao Tome and	Uzbekistan
Brunei	Ecuador	Kiribati	Myanmar	Principe	Vanuatu
Darussalam	El Salvador	Kuwait	Namibia	Senegal	Venezuela
Bulgaria	Equatorial Guinea	Kyrgyzstan	Nauru	Serbia	(Bolivarian
Burkina	Eritrea	Lao People's	Nepal	Seychelles	Republic of)
Faso	Estonia	Democratic	Nicaragua	Sierra Leone	Vietnam
Burundi	Ethiopia	Republic	Niger	Singapore	Yemen
Cabo Verde	Fiji	Latvia	Nigeria	Solomon Islands	Zambia
Cambodia	French Polynesia	Lesotho	Northern Mariana	Somalia South Africa	Zimbabwe
Cameroon	Gabon	Liberia	Islands	South Sudan	

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to <http://www.who.int/tb/country/en/>.

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3. Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease (if yes, please CHECK above)? Yes No

 4. Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? Yes No

 5. Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? Yes No

 6. Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? Yes No

If the answer is YES to any of the above questions, you are required to have TB testing prior to the start of classes and provide documentation. If the answer to all of the above questions is NO, no further testing or further action is required.

* The significance of the travel exposure should be discussed with a health care provider and evaluated.