New England Institute of Technology
HEALTH & IMMUNIZATION FORM FOR STUDENTS IN HEALTH SCIENCES PROGRAMS

Name of Student: ____ **Date of Birth** ____________

Program of Study: __________________________ ☐ Resident Student ☐ Non-Resident Student

In accordance with the Rhode Island Department of Health *Rules and Regulations Pertaining to Immunization, Testing, and Health Screening for Health Care Workers,* students in the Health Sciences Programs must have this **form filled out completely and signed by a physician.** 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.

ATTACH DOCUMENTATION – Lab report(s) and immunization records

Mantoux (PPD) Test: (2 step) test within the last 12 months

1st Test planted: __/___/___ Site: ________ Read __/___/___ Negative ☐ Positive ☐ Reading Value ________ mm
2nd Test planted __/___/___ Site: ________ Read __/___/___ Negative ☐ Positive ☐ Reading Value ________ mm

Positive PPD Test Student MUST: Chest x-ray date:_________________ Result: _________________

- 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.

IGRA/QUANTIFERON TB Gold RESULT:_____________ ❑ **BCG VACCINE:**_________
Date Date

Titer required when Immunization records are unavailable.

Measles/Rubeola	#1 Vaccine: date_______	#2 Vaccine: date________	Titer: Date:_____________ Immune___ Not Immune___
Rubella	#1 Vaccine: date_______	#2 Vaccine: date________	Titer: Date:_____________ Immune___ Not Immune___
Mumps	#1 Vaccine: date_______	#2 Vaccine: date________	Titer: Date:_____________ Immune___ Not Immune___
Varicella (Chicken Pox)	#1 Vaccine: date_______	#2 Vaccine: date________	Titer: Date:_____________ Immune___ Not Immune___

Hepatitis B	3 doses ➡ 1st Dose ___/___/___ 2nd Dose ___/___/___ 3rd Dose ___/___/___	Titer Date: ________ _____ immune _____ not immune ➡	Repeat of Series: Date: __/___/___ Date: __/___/___ Date: __/___/___ ➡	Re-Titer 1-2 months: Titer Date: __/___/___

Meningococcal Vaccine: (required for residential students under age 22): Date of Vaccine____________

Seasonal Flu Vaccine: Date: ____/____/____

Tdap: Must have one dose of vaccine: tetanus vaccine [every ten years].
Vaccine __________ Date: ____/____/____ Site:_______ Lot #_____________

Polio: Primary series and booster dose, if born outside of the U.S. (not required for Nursing students):
Date of series: ____/____/____ Date of booster: ____/____/____

Color Blindness: (**Nursing/MLT** students only; applicable to the particular job function) **YES** **NO**

HEALTH CARE PROVIDER INFORMATION:

Date of most recent Physical: ____/____/____ **Performed by:** _________________________

Comments: ____

Name (print):____ **Phone**:____________________________________

Address:____

Signature:____ **Date:**______________________________________

All fees for service are the responsibility of the student. Return completed form to your Admission's Officer.