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 proof of vaccines

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 RESULT:_____ ❑ **BCG VACCINE:**_____
Date Date

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 Vaccine: __/___/___ ➡	Re-Titer 1-2 months: Titer Date: __/___/___
Meningococcal Vaccine (required for residential students under age 22)	Date of vaccine: __/___/___		
Hepatitis B	3 doses ➡ 1st Dose __/___/___ 2nd Dose __/___/___ 3rd Dose __/___/___	Titer Date: _____ _____ immune _____ not immune ➡	Booster Series Required Date: __/___/___ Date: __/___/___ Date: __/___/___ ➡	Re-Titer 1-2 months: Titer Date: __/___/___

Seasonal Flu Vaccine: Date: ____/____/____

Tdap: Must have single dose of vaccine if it has been two years or more since last dose of Td vaccine (attach documentation).

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 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.