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)	____/____/____	____/____/____	***Or date of disease:*** ____/____/____	***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:_____ ❑ **BCG VACCINE:**_____
Date Date

PPD (Mantoux)

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

FOR VETERINARY TECHNOLOGY ONLY:

Pre-exposure Schedule for Rabies Vaccination* (Attach documentation) – Date of Injections:	**Previous Dates of Rabies Series*** (Attach documentation) – Date of Injections:	**Date of Rabies Current Titer*** (Attach lab report documentation)
1st Dose (as appropriate) ____/____/____	1st Dose ____/____/____	___/____/____
2nd Dose (7 days after Dose 1) ____/____/____	2nd Dose ____/____/____	Result: _____
3rd Does (21 days after Dose 1) ____/____/____	3rd Dose ____/____/____	

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

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/.

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.*