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.