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

(MAA) Medical Administrative Assistant; (MLT) Medical Lab Technician; (NUR) PN, AS & MSN Programs; (OT) Occupational Therapy MSOT & OTA programs; (RC) Respiratory Therapy; (ST) Surgical Tech; (PT) Physical Therapy

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

Program of Study:______________________________ ☐ Resident Student on campus ☐ 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 until the requirements are met.

ATTACH DOCUMENTATION –IMMUNIZATION RECORDS (due prior to the start of 1st class) and Lab report(s).

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:_____________ (Date) ❑ **BCG VACCINE:**_________ (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:____/____/____

COVID-19 Vaccine: Brand: __________ 1st vaccine date ______ 2nd vaccine date: ______ Booster #1 _____ Booster #2_______

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: ***All fees for service are the responsibility of the student.***
Upload completed form to Exxat at https://steps.exxat.com/

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

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

Address:____

Signature:____**Date:**____________________________