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 ; (MSLP) Speech Language Pathology

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:**_____