THE UNIVERSITY OF RHODE ISLAND
1892–2017

DIVISION OF STUDENT AFFAIRS
DR. PAULINE B. WOOD HEALTH SERVICES
6 Butterfield Road, Potter Building, Kingston, RI 02881 USA p: 401.874.2246 f: 401.874.2586 health.uri.edu

Immunization Record

THINK BIG WE DO℠

UPLOAD THIS FORM IN THE PATIENT PORTAL BY VISITING HEALTH.URI.EDU

YOU CAN SUBMIT A SIGNED IMMUNIZATION RECORD FROM YOUR PRIMARY CARE PROVIDER OR THIS FORM MAY BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER

STUDENTS WHO FAIL TO PROVIDE PROOF OF THE REQUIRED IMMUNIZATIONS WILL NOT BE PERMITTED TO REGISTER FOR CLASSES.

College ID # _____ **Student Cell Phone #** ***(REQUIRED)*** _____

Student Name: _____ **Date of Birth:** _____
(Please print) Last Name First Name MI

☐ FEMALE
☐ MALE

While Health Services recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that your legal name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronoun are different, please let us know.

REQUIRED

- **MEASLES, MUMPS, RUBELLA (MMR):** Two doses of MMR are required at least one month apart ***or*** positive immune titer verifying immunity.

  MMR Dose 1 ___/___/___ Dose 2 ___/___/___ ***OR*** Positive Titer ___/___/___

- **HEPATITIS B:** Three doses (doses one and two given four weeks apart and the third dose should be at least four months after first dose) or positive immune titer verifying immunity.

  Dose 1 ___/___/___ Dose 2 ___/___/___ Dose 3 ___/___/___ ***OR*** Positive Titer ___/___/___

- **TETANUS, DIPHTHERIA, PERTUSSIS (Tdap):** Tdap ___/___/___*

  * Tdap – One dose of Tdap is required in lifetime (not to be confused with childhood DTaP vaccine)

- **TETANUS (Td or Tdap):** Tdap ___/___/___ * ***OR*** Td ___/___/___

  * Td or Tdap booster is required within the past 10 years. If first and only Tdap was given in the past 10 years, requirement is met.

- **MENINGOCOCCAL VACCINE:** (MCV4) Dose 1 ___/___/___ Dose 2* ___/___/___

  * Required if under 22 years old. If you were vaccinated prior to your 16th birthday, a booster dose is also required.

- **VARICELLA:** Two doses of chicken pox vaccine are required at least one month apart ***or*** positive immune titer verifying immunity ***or*** medical provider's documented history of disease.

  Dose 1 ___/___/___ Dose 2 ___/___/___ ***OR*** Positive titer ___/___/___ ***OR*** Disease History ___/___/___

- **TUBERCULOSIS: * COMPLETE Tuberculosis (TB) Screening Form** (page 4) **and, if required, TB Risk Assessment** (page 5).

OTHER

- **SEASONAL FLU:** ___/___/___

- **HEPATITIS A:** Dose 1 ___/___/___ Dose 2 ___/___/___

- **HUMAN PAPILLOMAVIRUS VACCINE (HPV):** Dose 1 ___/___/___ Dose 2 ___/___/___ Dose 3 ___/___/___

- **MENINGOCOCCAL SEROGROUP B:*** Dose 1 ___/___/___ Dose 2 ___/___/___ Dose 3 ___/___/___

  * *This is not the same as Meningococcal (MCV4)*

- **POLIO:** ___/___/___

- **OTHER IMMUNIZATIONS**:

_____

_____

- **MEDICAL / RELIGIOUS EXEMPTION:** ☐ **Yes** * ***Exemption Certificate Required***

Health Care Provider: _____ Date: _____
(Please print)

Signature and Title: _____ Office Phone: _____