REQUIRED IMMUNIZATION RECORD
To Be Completed By Health Care Provider

Name:____ Date of Birth: ________________________

Student ID#: ____________________________________

THE FOLLOWING IMMUNIZATIONS ARE REQUIRED BY RI DEPARTMENT OF HEALTH FOR ALL STUDENTS

DPT/DT/TDAP	Must have one (1) Tdap & also last dose of Td or Tdap must be within last 10 years
MMR	Two doses of MMR (Measles, Mumps, Rubella) both given after 12 months of age, or disease confirmed by office record or positive titre
VARICELLA (chicken pox)	Two doses of varicella required, or disease confirmed by office record or positive titre.
HEPATITIS B	Three doses Hepatitis B vaccine required, or positive titre, or two adult doses between the ages of 11-15
MENINGITIS VACCINE	One dose of meningococcal conjugate (MCV4) vaccine is required for students previously unvaccinated (under 22 years of age). A second booster dose is required if the first dose was given before 16 years of age.

THE FOLLOWING VACCINES ARE REQUIRED INCLUDING DATES (MM/DD/YY) OF IMMUNIZATIONS OR POSITIVE TITRE.

IMMUNIZATION						
DPT/TD	Dose #1 __/__/__	Dose #2 __/__/__	Dose #3 __/__/__	Dose #4 __/__/__	Date of Td booster within 10 years __/__/__	Tdap booster within 10 years __/__/__
MMR *2 doses required	Dose #1 __/__/__	Dose #2 __/__/__		Titre Date __/__/__	Titre Result	
Measles			Date of Disease __/__/__	Titre Date __/__/__	Titre Result	
Mumps			Date of Disease __/__/__	Titre Date __/__/__	Titre Result	
Rubella			Date of Disease __/__/__	Titre Date __/__/__	Titre Result	
Hepatitis B	Dose #1 __/__/__	Dose #2 __/__/__	Dose #3 __/__/__	Titre Date __/__/__	Titre Result	
Varicella	Dose #1 __/__/__	Dose #2 __/__/__	Date of Disease __/__/__	Titre Date __/__/__	Titre Result	
Meningococcal Vaccine (MCV_4)	Dose #1 __/__/__	Dose #2 __/__/__				

THE FOLLOWING VACCINES ARE RECOMMENDED BUT NOT REQUIRED.

HPV Vaccine	Dose #1 __/__/__	Dose #2 __/__/__	Dose #3 __/__/__

Meningitis B Vaccine	Dose #1 __/__/__	Dose #2 __/__/__

TUBERCULIN SKIN TEST - PPD required within the past year if high risk.
Tuberculosis Risk Screening Questionnaire must be completed to determine risk.

IGRA/QUANTIFERON RESULT ____________
Date

☐ **LOW RISK.** PPD not required. ☐ **HIGH RISK.** PPD required. ☐ **BCG VACCINE:** ____________
Date

PPD (MANTOUX)

Date Given	Date Read	Results		Chest X-ray (if PPD is positive)
__/__/__	__/__/__			Date:
__/__/__	__/__/__			Results:
__/__/__	__/__/__			Treatment:

HEALTH PROVIDER INFORMATION:

Name (print):______________________________ Phone Number: __________________

Address:____

Signature of Health Provider:________________________ Date: __________________