Immunization Form for International College Students

In accordance with the Rhode Island Department of Health's Rules and Regulations Pertaining to Immunizations and Testing for Communicable Diseases for Students Entering Colleges or Universities (R23-1-IMM/COL), the following student populations must complete and return this form.

- All incoming full-time students in any program of study must complete section A and have section B completed and signed by a licensed health care provider with the exception of high school records or VA records. Students in a health care field of study should refer to immunization forms provided by their department.
- Any student who cannot access childhood records can have a titer done.
- International students are required to have a 2-part PPD test.

Part A: Personal Student Information:

Date: _____ CCRI ID*: _____

Student's name: _____ Date of birth: _____
Last, First, MI MM/DD/YY

Telephone number: _____ Email address: _____

Program of study: _____ ☐ ☐

Part B: Immunization Information – All information is REQUIRED.

							Was titer done? Acceptable in place of vaccine dates if unable to obtain immunization records.
MMR	1st dose	_____ MM/DD/YY	2nd dose	_____ MM/DD/YY			☐ Attach lab work
Hepatitis B	1st dose	_____ MM/DD/YY	2nd dose	_____ MM/DD/YY	3rd dose	_____ MM/DD/YY	☐ Attach lab work
OR HEP B (Heplisav)	1st dose	_____ MM/DD/YY	2nd dose	_____ MM/DD/YY			☐ Attach lab work
Varicella (Chicken Pox)	1st dose	_____ MM/DD/YY	2nd dose	_____ MM/DD/YY			☐ Attach lab work
Tdap	Date:	_____ MM/DD/YY					
PPD	1st test	_____ MM/DD/YY	Result: _____ mm		2nd test	_____ MM/DD/YY	Result: _____mm
*Please note, the optimal internal between the first and second dose is 1-3 weeks, the maximum allowable is 364 days.							
OR IGRA		_____ MM/DD/YY	Result: Positive ☐	Negative ☐			☐ Attach lab work

Meningitis	1st dose	_____ MM/DD/YY	Strongly recommended under age 22.	2nd dose	_____ MM/DD/YY	If 1st dose given prior to age 16.
Meningitis B	1st dose	_____ MM/DD/YY	Strongly recommended under age 22	2nd dose	_____ MM/DD/YY	If 1st dose given prior to to age 16

Health Care Provider signature _____ Date: _____ Submit form to: nurse@ccri.edu
Telephone _____

Please note that if you have graduated from a Rhode Island high school within the past five years, you should be able to obtain a copy of your immunizations from that high school.

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