# MANDATORY IMMUNIZATION RECORD

Providence College policy and Rhode Island State law require the College to keep a medical immunization form on file for all full-time students. Immunity is required prior to registration. Acceptable evidence **must** include day, month, year, and type/name of each dose of vaccine administered.
**To be completed and signed by physician or attach valid proof.**

**STUDENT'S NAME** _____ **DATE OF BIRTH**_____ **CELL** _____

**CURRENT ADDRESS**_____**CITY**_____**STATE**_____**ZIP**_____**BANNER ID#**_____

***A. TETANUS-DIPTHERIA-Required***

1. Tetanus-Diphtheria booster within last ten years — DATE: mm/dd/yyyy _____

***B. M.M.R.*** (Measles, Mumps, Rubella) ***Two doses required***

1. Dose 1 (on or after first birthday) — DATE: mm/dd/yyyy _____
2. Dose 2 — DATE: mm/dd/yyyy _____

***C. VARICELLA (CHICKEN POX)--Required***

1. Had disease — DATE: mm/dd/yyyy _____
2. Vaccinated – Dose 1 — DATE: mm/dd/yyyy _____
   Dose 2* — DATE: mm/dd/yyyy _____

*2nd Varicella vaccine is required if 1st dose was administered on or after the 13th birthday

**D. POLIO --** Completed primary series of polio vaccinations — YES_____NO_____
Type of vaccine — ORAL____ IPV_____
Last booster — DATE: mm/dd/yyyy _____

E. **HEPATITIS B Series --** ***Required***

1. Dose 1 — DATE: mm/dd/yyyy _____
2. Dose 2 — DATE: mm/dd/yyyy _____
3. Dose 3 — DATE: mm/dd/yyyy _____

**TUBERCULOSIS – SCREENING**

1. Does the student have signs or symptoms of active TB disease? YES_____NO_____
   **If NO**, proceed to question 2.
   If YES, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.
2. Is the student a member of a high-risk group* (see other side) or is the student entering the health professions?
   YES_____ NO_____
   **If NO, stop**. No further evaluation is needed at this time.
   If YES, you will need to have a Tuberculin skin test. A history of BCG vaccination should not preclude testing of a member of a high-risk group.
3. Tuberculin Skin Test:
   Date administered ___/___/____ Date read ____/____/____
   Result:_____ (Record actual mm of duration, transverse diameter. If no induration, write "0")
   Interpretation (based on mm of induration as well as risk factors). Positive___ Negative___
4. Chest X-ray (required if tuberculin skin test is positive):
   Result: Normal _____ Abnormal_____ Date of chest x-ray____/____/____

**HEALTH CARE PROVIDER:**

_____ _____
Name Date

_____
Address (street, city, state, zip)

_____ _____ _____
Telephone Number Fax Number Signature (required)

*1. The American College Health Association has published guidelines on tuberculosis screening of college and university students. These guidelines are based on recommendations from Centers for Disease Control and the American Thoracic Society. For more information, visit www.acha.org or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments or at the following website: www.cdc.gov/nchstp/tb/pubs/corecurr/.

2. Categories of high-risk students include those students who have arrived within the past five years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samos, Australia or New Zealand. Other categories of high risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in , or worked in high-risk congregate settings such as, prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone > 15 mg/d for > one month) or other immune-suppressive disorders.