Student Name:_____ Date of Birth: _____

**PROVIDENCE COLLEGE STUDENT HEALTH CENTER |(401) 865-2422**
**Personal and Confidential**

IMMUNIZATION RECORD *Please supply EMR vaccination or have your at-home provider fill out and sign below.*

**REQUIRED IMMUNIZATIONS**

| | | | |
|---|---|---|---|
| **Hepatitis B**<br>3 doses required | Date of Dose #1: | Date of Dose # 2: | Date of Dose #3: |
| *or* **Hepatitis B Titer** | ☐ pos ☐ neg - attach report<br>Date: | | |
| **MMR (Measles, Mumps, Rubella)**<br>2 doses required or individual vaccines as listed below | Date of Dose #1:<br>Given at 12 months after birth or later | Date of Dose #2:<br>Given at least 1 month after first dose | |
| **Measles (Rubeola)**<br>Students born prior to 1957 are required to have at least one dose | Date of Dose #1: | Date of Dose #2: | or Record of Titer -attach report<br>☐ pos ☐ neg Date: |
| **Mumps**<br>Required for all students regardless of age | Date of Dose #1:<br>Immunized with live vaccine at 12 months after | Date of Dose #2:<br>Given at least 1 month after the first dose | or Record of Titer –attach report<br>☐ pos ☐ neg Date: |
| **Rubella (German Measles)**<br>Required for all students regardless of age | Date of Dose #1:<br>Immunized with live vaccine at 12 months after | Date of Dose #2:<br>Given at least 1 month after the first dose | or Record of Titer – attach report<br>☐ pos ☐ neg Date: |
| **Meningococcal Vaccine**<br>(A, C, Y, W-135)<br>Required if under 22 years old | ☐ Menactra<br>☐ Menomune<br>☐ Menveo<br>☐ Other: | Date of Dose #1 | Date of Booster Dose:<br>**Required if dose 1 was given before 16 years old** |
| **Tdap (Tetanus-Diphtheria- Pertussis)**<br>Must be within the past 10 years | Date of Dose: | | |
| **Varicella (Chicken Pox)**<br>History of disease or 2 doses required or positive titer | Date of Dose # 1:<br><br>Date of Dose # 2: | or History of Disease<br><br>Date: | or Record of Titer – attach report<br>☐ pos ☐ neg Date: |

**OTHER IMMUNIZATIONS**

| | | | |
|---|---|---|---|
| **Hepatitis A** | Date of Dose #1: | Date of Dose #2: | |
| **HPV**<br>(indicate HPV-4 or HPV-9 ) | Date of Dose #1: | Date of Dose #2: | Date of Dose #3: |
| **Meningococcal B Vaccine (Trumenba or Bexsero)** | Date of Dose #1: | Date of Dose #2: | Date of Dose #3: |
| **Polio** (most recent booster) | Date: | | |
| **Rabies** | Date of Dose #1: | Date of Dose #2: | Date of Dose #3: |
| **Typhoid** | Date: | ☐ Oral<br>☐ Injectable | |
| **Other** (Flu, Pneumovax, Yellow Fever, Japanese Encephalitis) | | | |

Provider Name (*please print*): _____

Provider Signature (*required*): _____

Address: _____
Street City State Zip

Phone:_____Fax: _____