

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

OTHER IMMUNIZATIONS

Hepatitis A	Date of Dose #1:	Date of Dose #2:	
HPV (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:	<input type="checkbox"/> Oral <input type="checkbox"/> Injectable	
Other (Flu, Pneumovax, Yellow Fever, Japanese Encephalitis)			

Provider Name (please print): _____

Provider Signature (required): _____

Address: _____
Street
City
State
Zip

Phone: _____ Fax: _____