THE UNIVERSITY OF RHODE ISLAND
DIVISION OF STUDENT AFFAIRS

Immunization Record

UPLOAD THIS FORM IN THE PATIENT PORTAL BY VISITING: HEALTH.URI.EDU

THINK BIG WE DO

DR. PAULINE B. WOOD HEALTH SERVICES
6 Butterfield Road, Potter Building, Kingston, RI 02881 USA p: 401.874.2246 f: 401.874.2586 http://health.uri.edu

OFFICIAL IMMUNIZATION DOCUMENTATION FROM YOUR PRIMARY CARE PROVIDER CAN BE USED IN LIEU OF THIS FORM. INTERNATIONAL STUDENTS, PLEASE USE THIS FORM.

College ID #_____ **Student Cell Phone # (REQUIRED)** _____

Student Name: _____ **Date of Birth:** _____
(Please Print) Last Name First Name MI

REQUIRED

- **MEASLES, MUMPS, RUBELLA (MMR):** (MMR or MMRV) Two doses of MMR are required (dose #1 after first birthday and dose #2 at least one month after dose #1) or positive immune titers verifying immunity.
  MMR Dose 1 _____/_____/_____ **Dose 2** _____/_____/_____ **OR** **Positive Titers** _____/_____/_____
- **HEPATITIS B:** Three doses (dose one and two given four weeks apart and the third dose must be at least four months after the first dose); Two doses of Heplisav or positive/reactive immune titer verifying immunity.
  Dose 1 ____/____/____ **Dose 2** ____/____/_____ **Dose 3** ____/____/____ **OR** **Positive Titer** _____/_____/_____
- **Tdap (TETANUS, DIPHTHERIA, PERTUSSIS):** Tdap ____/____/____*
  *Tdap - One dose of Tdap is required in lifetime, not to be confused with childhood DTaP vaccine or Td (tetanus diphtheria only) vaccine.
- **MENINGOCOCCAL VACCINE:** (Menactra, Menveo, MenQuadfi, or MCV4) **Date*** ____/____/____
  *Required if under 22 years old. Immunization date must be within the last 5 years. If first dose prior to 16th birthday, booster dose is also required. Not to be confused with Meningococcal Serogroup B vaccine (Bexsero or Trumenba).
- **VARICELLA:** (Varivax or MMRV) Two doses of varicella vaccine are required (dose #1 after first birthday and dose #2 at least one month after dose #1) or positive immune titer verifying immunity ***or*** medical provider's documented history of disease.
  Dose 1 ____/____/____ **Dose 2** ____/____/____ **OR** **Positive titer** ____/____/_____ **OR** **History of Disease** ____/____/____

RECOMMENDED

As medically appropriate:

- **COVID-19: Please check one** ☐ **Moderna** ☐ **Pfizer** ☐ **Johnson & Johnson** ☐ **Other** _____
  Dose 1 ____/_____/____ **Dose 2** ____/_____/_____ (as applicable) **Booster** ____/____/____ **Booster** ____/____/____
- **SEASONAL FLU (Influenza):** ____/____/____
- **HEPATITIS A: Dose 1** ____/_____/____ **Dose 2** ____/_____/_____
- **HUMAN PAPILLOMAVIRUS VACCINE** (HPV or HPV-9 or Gardasil)**:**
  Dose 1 ____/____/____ **Dose 2** ____/____/____ **Dose 3** ____/____/____
- **MENINGOCOCCAL SEROGROUP B: * Dose 1** ___/___/___ **Dose 2** ____/____/____ **Dose 3** ____/____/____
  *This is not the same as Meningococcal (MCV4). It is sometimes under the names Bexsero or Trumenba.
  TETANUS (TD): TD____/____/____*Td or Tdap booster is recommended every 10 years
- **POLIO (date of most recent dose):** ____/____/_____
- **PNEUMOCOCCAL (date of most recent dose):** ____/_____/____
- **OTHER:** _____
- **MEDICAL/ RELIGIOUS EXEMPTION (other than COVID-19):** ☐ **Yes** **** Exemption Certificate Required***

Health Care Provider: _____ **Date:** _____
(Please print)

Signature and Title: _____ **Office Phone:** _____