

College of Nursing ▪ University of Rhode Island

IMMUNIZATION RECORD

Please Print.

Name: _____ Birth Date: _____

Social Security #: _____ Expected Graduation Date: _____

URI ID #: _____

In signing this form I acknowledge:

I give the College permission to release this information and any updates to clinical agencies as needed.

Student Signature: _____ **Date:** _____

CPR Certification: _____ **Expiration Date:** _____

(Attach a Xerox copy of both sides of your card.)

Tuberculosis Screening: Two step PPD testing is required by our clinical agencies. The two PPDs must be within one year of each other.

Date initial PPD planted: _____ Date read: _____ Result: _____ mm

Date second PPD planted: _____ Date read: _____ Result: _____ mm

History of positive PPD; Date: _____

If PPD is positive:

Submit documentation of adequate chemotherapy for TB or
a negative chest x-ray Date: _____

PPD contraindicated: _____ (explain)

MMR (Measles, Mumps & Rubella vaccine) 2 doses are required: Date #1: _____ Date #2: _____

If the MMR vaccine was not received, please fill out the following.

Rubella

Rubella immunization, Date: _____, OR

Serologic evidence of acquired immunity, Date: _____, Results: _____ OR

Contraindication to immunization: _____ (explain)

Measles (Rubeola)

Documentation of two (2) doses of live-virus measles vaccine (for persons born after 12/31/56); one dose required if born on or before 12/31/56); Date #1: _____ and Date #2: _____ OR

Serologic evidence of acquired immunity, Date: _____, Results: _____ OR

Proof of physician documented illness, Date: _____, OR

Contraindication to immunization: _____ (explain)

Mumps

Mumps immunization, Date: _____, OR

Serologic evidence of acquired immunity, Date: _____, Results: _____ OR

Contraindication to immunization: _____ (explain)

Varicella

Proof of physician documented illness, Date: _____, OR

If vaccine was received when 13 years or older, two doses of Varicella vaccine, at least 1 month apart are required;

Date #1: _____ #2: _____ OR

If vaccine was received less than 13 years of age, one dose of Varicella vaccine is required;

Date #1: _____

Serologic evidence of acquired immunity, Date: _____, Results: _____ OR

Contraindication to immunization: _____ (explain)

Tetanus / Diphtheria

TD booster (within the past 10 years), Date: _____ OR

Contraindication to immunization: _____ (explain)

Hepatitis B

Hepatitis B Vaccine doses; Dates: #1: _____ #2: _____ #3: _____ OR

Serologic evidence of acquired immunity, Date: _____, Results: _____ OR

Hepatitis B Vaccine Refusal Form signed, dated and attached, OR

Contraindication to immunization: _____ (explain)

Color Blindness Screening

Date of screening: _____ Result: _____

Provider / Nurse Signature: _____ Date: _____