

New England Institute of Technology  
**HEALTH & IMMUNIZATION FORM FOR STUDENTS IN HEALTH SCIENCES PROGRAMS**

Name of Student: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Program of Study: \_\_\_\_\_ Resident Student Non-Resident Student

In accordance with the Rhode Island Department of Health Rules and Regulations Pertaining to Immunization, Testing, and Health Screening for Health Care Workers, students in the Health Sciences Programs must have this form filled out completely and signed by a physician. Students who fail to provide proof of required immunizations will not be permitted to attend class or move into the residence hall until the requirements are met.

ATTACH DOCUMENTATION: Lab report(s) and immunization records

**Mantoux (PPD) Test**(2 step) test within the last 12 months

1<sup>st</sup> Test planted: \_\_/\_\_/\_\_ Site: \_\_\_\_\_ Read \_\_/\_\_\_ Negative Positive Reading Value \_\_\_\_\_ mm

2<sup>nd</sup> Test planted \_\_/\_\_/\_\_ Site: \_\_\_\_\_ Read \_\_/\_\_\_ Negative Positive Reading Value \_\_\_\_\_ mm

**Positive PPD Test Student MUST** Chest xray date: \_\_\_\_\_ Result: \_\_\_\_\_

Provide proof of negative chest xray taken after an initial positive test result.

Have a health care provider complete and submit the Tuberculosis Symptom Assessment form

IGRA/QUANTIFERON TB Gold RESULT \_\_\_\_\_ q BCG VACCINE: \_\_\_\_\_

Date Date

**Measles/Rubeola** #1 Vaccine: date \_\_\_\_\_ #2 Vaccine: date \_\_\_\_\_ Titer: Date: \_\_\_\_\_ q 15!

			Immune ___ Not Immune ___
<b>Mumps</b>	#1 Vaccine: date _____	#2 Vaccine: date _____	