RISD Health Services
20 Washington Place
Providence, RI 02902
(401) 454-6625 (phone)
(401) 454-6628 (fax)

Immunization Record

Not valid without a medical provider signature

Date of Birth (MM/DD/YY): ___/___/___
Last Name: First Name: Middle Initial:

Required Immunizations

Hepatitis B 3 doses of Hepatitis B; 2 doses of Heplisav-B; OR serologic proof of immunity for Hepatitis B			
Option 1:			
Hepatitis B **3 dose vaccines**	Date Dose #1:	Date Dose #2:	Date Dose #3:
Option 2:			
Heplisav-B only	Date Dose #1	Date Dose #2	
Option 3:			
Hepatitis B Titer	○ Positive ○ Negative	Date:	*Copy of result required
Measles, Mumps, Rubella (MMR) 2 doses of MMR vaccine received after age 1; OR serologic proof of immunity for Measles, Mumps, and Rubella.			
Option 1:			
MMR	Date Dose #1:	Date Dose #2:	
Option 2:			
Measles Titer	○ Positive ○ Negative	Date:	*Copy of result required
Mumps Titer	○ Positive ○ Negative	Date:	*Copy of result required
Rubella Titer	○ Positive ○ Negative	Date:	*Copy of result required
Meningococcal Quadrivalent (A, C, Y, W-135) Required only if under 22 years old; 1 dose with an additional booster dose if 1st dose received prior to age 16			
Meningococcal Quadrivalent Vaccine (Not Men B)	Date Dose #1:_____ ○ Menactra ○ MenQuadfi ○ Menveo ○ Other (specify) ○ _____	Date Booster:_____ ○ Menactra ○ MenQuadfi ○ Menveo ○ Other (specify) ○ _____	
Tdap (Tetanus-Diphtheria-Pertussis) 1 dose of adult Tdap; if last Tdap is more than 10 years old, provide date of last Td or Tdap booster			
Tdap (Not DTaP)	Date Dose #1:	Date Booster: _____ ○ Tdap ○ Td	

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Varicella 2 doses of Varicella vaccine OR history of disease OR serologic proof of immunity for Varicella.			
Option 1:			
Varicella	Date Dose #1:	Date Dose #2:	
Option 2:			
Varicella	○ History of Disease	Date of disease:	
Option 3:			
Varicella Titer	○ Positive ○ Negative	Date:	*Copy of result required

Recommended Immunizations (Not Required)

Updated COVID Booster Vaccine	
Date of most recent dose:	
Annual Influenza Vaccine	
Date of most recent dose:	
Hepatitis A	
Date Dose #1:	Date Dose #2:
HPV	
Date Dose #1:	Date Dose #2:
Meningococcal B	
Date Dose #1: ○ Bexsero ○ Trumenda	Date Dose #2: ○ Bexsero ○ Trumenba

Medical Provider Signature:_____ Date: _____

Medical Provider Name (print) or stamp:_____

Address:_____

Phone: _____ Fax:_____

*Please Note
This form will be rejected if not signed by a health care provider
Put your name and date of birth on both pages
Return completed form to RISD Health Services by uploading to patient portal