

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	<input type="radio"/> Positive <input type="radio"/> Negative	Date:	
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	<input type="radio"/> Positive <input type="radio"/> Negative	Date:	
Mumps Titer	<input type="radio"/> Positive <input type="radio"/> Negative	Date:	
Rubella Titer	<input type="radio"/> Positive <input type="radio"/> Negative	Date:	
Meningococcal Quadrivalent (A, C, Y, W-135)			
Required only if under 22 years old; 1 dose with an additional booster dose if 1 st dose received prior to age 16			
Meningococcal Quadrivalent Vaccine (Not Men B)	Date Dose #1: _____ <input type="radio"/> Menactra <input type="radio"/> MenQuadfi <input type="radio"/> Menveo <input type="radio"/> Other (specify) _____ <input type="radio"/> _____	Date Booster: _____ <input type="radio"/> Menactra <input type="radio"/> MenQuadfi <input type="radio"/> Menveo <input type="radio"/> Other (specify) _____ <input type="radio"/> _____	
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: _____	<input type="radio"/> Tdap <input type="radio"/> 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	<input type="radio"/> History of Disease	Date of disease:
Option 3:		
Varicella Titer	<input type="radio"/> Positive <input type="radio"/> Negative	Date:

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: <input type="radio"/> Bexsero <input type="radio"/> Trumenda	Date Dose #2: <input type="radio"/> Bexsero <input type="radio"/> 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