RANKEN
TECHNICAL COLLEGE

# RESIDENTIAL LIFE

## RESIDENT IMMUNIZATION FORM

Full Name: _____ Date of Birth: _____

Address: _____ City/State: _____ Zip: _____

**IMMUNIZATION REQUIREMENTS**

**All students must complete the following vaccination requirements no later than 30 days after moving into the residence hall.** Failure to fulfill this requirement may jeopardize your housing assignment. All students must mail or bring in a completed vaccination form, medical history form, and meningitis requirement and waiver form to the Residential Life Office.

A completed immunization form and medical history form must be returned to the Residential Life Office no later than 30 days after moving into the residence hall. Please email to reslife@ranken.edu, fax to 314-371-0241 or mail these materials to:
**Director of Residential Life/Ranken Technical College/4431 Finney Avenue/St. Louis, MO 63113**

### MANDATORY IMMUNIZATIONS

The following immunizations are MANDATORY and must be updated or must provide documentation that you have received the required immunization.

| Vaccine | Date of Immunization | Date of Immunization | Date of Immunization |
|---|---|---|---|
| COVID Vaccine | Dose 1 ___ / ___ / ___ | Dose 2 ___ / ___ / ___ | The vaccination card is required to be shown on Move In Day for verification. |
| Varicella (chicken pox) | Dose 1 ___ / ___ / ___ | Dose 2 ___ / ___ / ___ | Or confirmed date of disease: ___ / ___ / ___ |
| M.M.R. (Mumps, Measles, Rubella) | Dose 1 ___ / ___ / ___ | Dose 2 ___ / ___ / ___ | |
| Tetanus booster ***Must be administered within last 10 years.*** | Dose ___ / ___ / ___ | Booster type: ☐ Td ☐ Tdap | |
| Meningitis | Dose ___ / ___ / ___ | Vaccination type: _____ | |
| Tuberculin Skin Test ***Test must be administered within 12 months prior to entering campus housing.*** | Date read: _____ Induration (mm): _____<br>Result: ☐ Positive ☐ Negative<br>A positive TST requires a chest x-ray. Please include chest x-ray radiological report with this form – do not send x-rays. Please complete information below if chest x-ray is administered:<br>Date of chest X-ray: _____ Result: ☐ Normal ☐ Abnormal | | |

### RECOMMENDED IMMUNIZATIONS

The following immunizations are RECOMMENDED but are not required in order to live in the dormitory.

| Vaccine | Date of Immunization | Date of Immunization | Date of Immunization |
|---|---|---|---|
| Hepatitis A | Dose 1 ___ / ___ / ___ | Dose 2 ___ / ___ / ___ | Dose 3 ___ / ___ / ___ |
| Hepatitis B | Dose 1 ___ / ___ / ___ | Dose 2 ___ / ___ / ___ | Dose 3 ___ / ___ / ___ |

**HEALTH CARE PROVIDER INFORMATION – Must be completed by a health care provider.**

Provider Name (Print): _____ Address: _____

Provider Signature: _____ Date: _____ Phone: (_____) _____

Revised 4/2021