



Immunization Record

Health Services
 450 Brook St,
 Providence, RI 02906
 401-863-3953

To return form, student must log in to <https://patientportal.brown.edu> and upload

Name _____ Date of Birth ____/____/____
 Last First Middle mm dd yy

Address _____
 Street City State Zip Code Country

REQUIRED IMMUNIZATIONS

COVID-19 A record of a one or two dose COVID-19 vaccine series AND a booster dose if >5 months after initial series completion			
COVID-19	Date of Dose #1: <input type="checkbox"/> Janssen (J & J) <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> Other (specify brand)	Date of Dose #2 (if applicable): <input type="checkbox"/> Janssen (J & J) <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> Other (specify brand)	Date of Booster dose: if >5 months after series completion: <input type="checkbox"/> Janssen (J & J) <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> Other (specify brand)
Hepatitis B 3 doses of Engerix-B, Recombivax or Twinrix, OR 2 doses of Heplisav-B			
Hepatitis B 3-dose vaccines (Engerix-B, Recombivax, Twinrix)	Date of Dose #1:	Date of Dose #2:	Date of Dose #3:
Or Hepatitis B 2 dose vaccine (Heplisav-B)	Date of Dose #1:	Date of Dose #2:	
Or Hepatitis B Titer	<input type="checkbox"/> positive <input type="checkbox"/> negative	Date:	Copy of lab result required
Measles, Mumps, Rubella (MMR) 2 doses of MMR vaccine OR 2 doses of Measles, 2 doses of Mumps and 1 dose of Rubella; OR serologic proof of immunity for Measles, Mumps and Rubella. Choose only one option.			
Option 1: 2 doses of MMR vaccine			
MMR 2 doses of MMR vaccine	Date of MMR Dose #1: Must be at 12 months after birth or later	Date of MMR Dose #2: Must be at least 1 month after first dose	
Option 2: 2 doses of Measles, 2 doses of Mumps and 1 dose of Rubella; OR serologic proof of immunity for Measles, Mumps and Rubella			
Measles (Rubeola) 2 doses of measles vaccine OR positive titer	Date of Dose #1: Must be at 12 months after birth or later	Date of Dose #2: Must be at least 1 month after the first dose	Or Measles Titer <input type="checkbox"/> positive <input type="checkbox"/> negative Date: Copy of lab result required
Mumps 2 doses of mumps vaccine OR positive titer	Date of Dose #1: Must be at 12 months after birth or later	Date of Dose #2: Must be at least 1 month after the first dose	Or Mumps Titer <input type="checkbox"/> positive <input type="checkbox"/> negative Date: Copy of lab result required
Rubella (German Measles) 1 dose of Rubella vaccine OR positive titer	Date of Dose #1: Must be at 12 months after birth or later	Or Rubella Titer <input type="checkbox"/> positive <input type="checkbox"/> negative Date: Copy of lab result required	

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REQUIRED IMMUNIZATIONS

Meningococcal (A, C, Y, W-135) Required only if under 22 years old, booster dose required only if dose was given prior to 16th birthday			
Meningococcal Vaccine <input type="checkbox"/> Menactra <input type="checkbox"/> Menomune <input type="checkbox"/> Menveo <input type="checkbox"/> Other:	Date of Dose #1:		Date of Booster Dose (if applicable):
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	Date of Dose:		Date of Booster Dose (if applicable):
Varicella (Chicken Pox) 2 doses of varicella vaccine OR history of disease OR serologic proof of immunity for varicella			
Varicella	Date of Dose # 1: Must be 12 months after birth or later	or History of Disease Date:	Or Varicella Titer <input type="checkbox"/> positive <input type="checkbox"/> negative Date: Copy of lab result required
	Date of Dose # 2:		

Recommended Immunizations (Not Required)

Hepatitis A	Date of Dose #1:	Date of Dose #2:	Date of Dose #3 (if applicable):
HPV	Date of Dose #1:	Date of Dose #2:	Date of Dose #3 (if applicable):
Meningococcal B	Date of Dose #1: <input type="checkbox"/> Trumenba <input type="checkbox"/> Bexsero	Date of Dose #2: <input type="checkbox"/> Trumenba <input type="checkbox"/> Bexsero	Date of Dose #3 (if applicable): <input type="checkbox"/> Trumenba
Polio	Date of most recent dose:		
Flu Vaccine	Date of most recent dose:		
Other (ex: Pneumovax, Yellow Fever, Japanese Encephalitis, Rabies, Typhoid, BCG)	Vaccine: Date:	Vaccine: Date:	Vaccine: Date:
	Vaccine: Date:	Vaccine: Date:	Vaccine: Date:

Signature of Physician/Medical Provider: _____ Date: _____

Physician/Medical Provider Name (Printed) or Clinic Stamp _____

Address _____

Phone number: _____ Fax Number: _____