BROWN

Immunization Record

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

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

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

Address _____
Street City State Zip Code Country

REQUIRED IMMUNIZATIONS

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**	❒ positive ❒ 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 ❒ positive ❒ 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 ❒ positive ❒ 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 ❒ positive ❒ negative Date: Copy of lab result required
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 ❒ Menactra ❒ Menomune ❒ Menveo ❒ Other:	Date of Dose #1:		Date of Booster Dose (if applicable):

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

REQUIRED IMMUNIZATIONS

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 Date of Dose # 2:	or History of Disease Date:	Or Varicella Titer ❒ positive ❒ negative Date: Copy of lab result required

Recommended Immunizations (Not Required)

COVID-19	Date of Dose #1: Specify brand:	Date of Dose #2 (if applicable): Specify brand:	Booster Dose: Specify brand:	Booster Dose: Specify brand:
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: ❒ Trumenba ❒ Bexsero	Date of Dose #2: ❒ Trumenba ❒ Bexsero	Date of Dose #3 (if applicable): ❒ 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: _____