BROWN
Campus Life

Student Health and Wellness
Box 1928
Providence, RI 02912
Phone: 401-863-3953
Fax: 401-863-7953

Immunization Record

To return form, student must login to http://studenthealthportal.brown.edu/ and upload.

Name: _____ **Date of Birth:** _____
Last First Middle mm / dd / yyyy

Address: _____
Street City State Zip Code Country

Required Immunizations - page one

Hepatitis B 3 doses of Engerix-B, Recombivax, 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** laboratory evidence of immunity for Measles, Mumps and Rubella. Choose only one option.			
Option one: 2 doses of MMR vaccine			
MMR 2-doses MMR vaccine	Date of MMR dose # 1: Administered on or after the first (1st) birthday	Date of MMR dose # 2: Must be at least 1 month after first dose	
Option two: 2 doses of Measles, 2 doses of Mumps and 1 dose of Rubella; **OR** laboratory evidence of immunity for Measles, Mumps and Rubella			
Measles (Rubeola) 2-doses Measles vaccine OR positive titer	Date of dose # 1: Administered on or after the first (1st) birthday	Date of dose # 2: Must be at least 1 month after first dose	Or Measles Titer ☐ Positive ☐ Negative Date: Copy of lab result required
Mumps 2-doses Mumps vaccine OR positive titer	Date of dose # 1: Administered on or after the first (1st) birthday	Date of dose # 2: Must be at least 1 month after first dose	Or Mumps Titer ☐ Positive ☐ Negative Date: Copy of lab result required
Rubella (German Measles) 1 doses Rubella vaccine OR positive titer	Date of dose # 1: Administered on or after the first (1st) birthday	Or Rubella Titer ☐ Positive ☐ Negative Date: Copy of lab result required	
Meningococcal ACWY Required for students under 22 years of age: booster dose required if last dose was given before age 16.			
Meningococcal Vaccine ☐ Menactra ☐ Menveo ☐ MenQuadfi ☐ Penbraya (MenABCWY) ☐ Penmenvy (MENABCWY) ☐ Other:	Date of dose # 1:	Date of booster dose (if first dose given before 16th birthday):	

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Required Immunizations - page two

T-dap (Tetanus, Diphtheria, Pertussis) 1 dose of adult T-dap; if last T-dap is more than 10 years old, provide date of last Td or T-dap booster		
T-dap	Date of dose:	Date of booster dose (if applicable): ☐ T-dap ☐ Td
Varicella (Chicken Pox) 2 doses of varicella vaccine or laboratory evidence of immunity for varicella		
Varicella (Chicken Pox)	Date of dose # 1: Administered on or after the first (1st) birthday	Date of dose # 2: Must be at least 1 month after first dose
		Or Varicella Titer ☐ Positive ☐ Negative Date: Copy of lab result required

Additional Immunizations (not required)

COVID-19	Date of most updated booster: 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				
Pneumococcal (recommended for certain risk conditions)	Select Type: ☐ Prevnar 13 (PCV13) ☐ Prevnar 20 (PCV20) ☐ Vaxneuvance (PCV15) ☐ Capvaxive (PCV21) ☐ Pneumovax (PPSV23)	Date of dose:					
Polio	Date of most recent dose:						
Flu Vaccine	Date of most recent dose:						
Other: (ex: Yellow Fever, Japanese Encephalitis, Rabies, BCG)	Vaccine: Date:	Vaccine: Date:	Vaccine: Date:	Vaccine: Date:	Vaccine: Date:	Vaccine: Date:	Vaccine: Date:

Signature of Physician / Medical Provider: _____ **Date:** _____

Physician / Medical Provider name (please pring/clinic stamp): _____

Address: _____

Phone: _____ Fax: _____