BROWN

Student Health Services
450 Brook St.
Providence, RI 02912
401-863-3953

To return form, student must log in at
http://studenthealthportal.brown.edu/
and upload

Medical Student Required Immunizations, Titers & Tuberculosis Screening

Brown University requires all medical students to provide written documentation of the following on the Medical Student Immunization, Titers & Tuberculosis Screening Record:

Medical Student Immunization, Titers & Tuberculosis Screening Record

- ❑ COVID-19
  Documentation of your original COVID vaccine series and/or your most recent COVID-19 vaccine dose. Please note that some clinical sites may require an up-to-date COVID-19 vaccination status, including the latest available booster dose

- ❑ Hepatitis B
  Documentation of a Hepatitis B vaccine series. After series completion, a **quantitative** Hepatitis B Surface Antibody titer must be completed, a copy of the lab report must be submitted.

- ❑ Measles, Mumps and Rubella (MMR)
  Documentation of two (2) MMR vaccines **OR** two (2) doses of Measles, two (2) doses of Mumps and one (1) dose of Rubella; **OR** serologic proof of immunity for Measles, Mumps and Rubella. History of disease is not acceptable. A copy of the lab reports must be submitted.

- ❑ Meningococcal A, C, Y, W-135
  Required for students 22 years old or younger: dose must be given after 16th birthday

- ❑ Tetanus/Diphtheria/Pertussis (Tdap)
  One dose of adult Tdap. If the last Tdap dose is more than 10 years old, then a Tetanus Diphtheria (Td) or Tdap booster is required.

- ❑ Varicella
  Documentation of two Varicella vaccines **OR** if a history of chickenpox disease, serologic proof of immunity for Varicella (chickenpox) is required. History of disease alone is not acceptable. A copy of the lab report must be submitted.

- ❑ Tuberculosis Screening
  Documentation of **two** tuberculosis skin tests (TST) – spaced 1-3 weeks apart **OR** one IGRA blood test (QuantiFERON Gold/T-SPOT), completed **within 6 months** prior to arrival at Brown. If there is a positive result to the TB Skin test or the IGRA Blood test, documentation of a negative chest x-ray **and/or** history of latent TB treatment must be submitted.

- ❑ Influenza
  The Influenza vaccine will be required this upcoming fall. Flu vaccine clinics will be held at the medical school, information will be forthcoming.

- ❑ Recommended, Not Required Vaccines
  Document any additional immunizations on page 2 and 3 of the immunization record form

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Medical Student Immunizations, Titers & Tuberculosis Screening Record

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

REQUIRED IMMUNIZATIONS

COVID-19 Documentation of your original COVID vaccine series OR most recent COVID-19 vaccine dose. Please note that some clinical sites may require an up-to-date COVID-19 vaccination status, including the latest available booster dose			
COVID-19	Date of Dose #1: Specify brand:	Date of Dose #2 (if applicable): Specify brand:	Date of most recent booster dose: Specify brand:
Hepatitis B 3 doses of Engerix-B, Recombivax or Twinrix, OR 2 doses of Heplisav-B, followed by a QUANTITATIVE Hepatitis B Surface Antibody (titer) drawn 4-8 weeks after the last dose. If negative titer complete a second Hepatitis B series followed by a repeat titer.			
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:	
And **Quantitative Hepatitis B Titer**	❒ positive ❒ negative	Date:	Copy of lab result required
Secondary Hepatitis B Series Only if negative titer after primary series	Date of Dose #1: Specify Brand:	Date of Dose # 2: Specify Brand:	Date of Dose #3 (if applicable): Specify Brand:
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	

Name _____ Date of Birth___/___/___
Last First Middle mm dd yy

REQUIRED IMMUNIZATIONS

Meningococcal Required for students 22 years old or younger: dose must be given after 16th birthday			
Meningococcal Vaccine ☐Menactra ☐Menomune ☐Menveo ☐MenQuadfi ☐Other:	Date of Dose #1:	Date of Booster Dose: (if first dose given before 16th birthday):	
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): ❒ Tdap ❒ Td	
Varicella (Chicken Pox) 2 doses of varicella vaccine or serologic proof of immunity for varicella			
Varicella (Chicken Pox) 2 doses required or positive titer	Date of Dose # 1: Must be given 12 months after birth or later	Date of Dose # 2: Must be at least 1 month after the first dose	Or Varicella Titer ❒ positive ❒ negative Date: Copy of lab result required
Tuberculosis Screening Two skin tests spaced 1-3 weeks apart **OR** one IGRA test (QuantiFERON Gold /T-SPOT) within 6 months of arrival to Brown. If history of LTBI, Positive TB Skin Test, or Positive TB IGRA Blood Test: documentation of a negative chest x-ray and/or history of latent TB treatment must be submitted			
Tuberculosis Skin Test (PPD) 2 skin tests 1-3 weeks apart within 6 months prior to arrival at Brown.	Date of Test #1:	Date of Read #1:	Result in mm #1:
	Date of Test #2:	Date of Read #2:	Result in mm #2:
Or **IGRA Testing** QuantiFERON Gold or T-SPOT	Date of Test:	Results: ❒ Positive ❒ Negative ❒ Indeterminate	Copy of lab result required
Chest X-ray Required only if PPD or IGRA test is positive.	Date of chest x-ray:	Results: ❒ Normal ❒ Abnormal	Copy of chest x-ray result must be submitted
Latent TB Treatment Required only after a positive TB test/negative chest x-ray	Type of Treatment:	Date Treatment Started:	Date Treatment Completed:

Additional 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: ❒ Trumenba ❒ Bexsero	Date of Dose #2: ❒ Trumenba ❒ Bexsero	Date of Dose #3 (if applicable): ❒ Trumenba

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

Additional Immunizations (Not Required)

Pneumovax (recommended for certain risk conditions)	Select Type: ❒ Prevnar 13 (PCV13) ❒ Prevnar 20 (PCV20) ❒ Vaxneuvance (PCV15) ❒ Capvaxive (PCV21) ❒ Pneumovax 23 (PPSV23) Date of Dose:					
Polio	Date of most recent dose:					
Typhoid	Date of most recent dose: ❒ Oral ❒ Injectable					
Other: (ex: Yellow Fever, Japanese Encephalitis, Rabies BCG)	Vaccine: Date:	Vaccine: Date:	Vaccine: Date:	Vaccine: Date:	Vaccine: Date:	Vaccine: Date:

Signature of Healthcare Provider: _____ Date: _____

Healthcare Provider Name: (Please Print) /Clinic Stamp _____

Address _____

Phone number: _____ Fax Number: _____