

## **Immunization Record**

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

To return form, student must log in to <a href="https://patientpportal.brown.edu">https://patientpportal.brown.edu</a> and upload

Name	Date of Birth / /										
Last	First Middle		n		nm dd yy						
Address											
AddressStreet	City	State	Z	p Code	Country						
	,				,						
REQUIRED IMMUNIZATIONS											
Hepatitis B 3 doses of Engerix-B, Recombivax or Twinrix, OR 2 doses of Heplisav-B											
Hepatitis B	Date of Dose #1:		Date of Dose #2:		Date of Dose #3:						
3-dose vaccines (Engerix-B, Recombivax, Twinrix)	Date of Dose	<i>π</i> 1.	Date of Bose #2.		Bate of Bose #5.						
, -											
Or Hepatitis B	Date of Dose #1:		Date of Dose #2:								
2 dose vaccine (Heplisav-B)  Or	☐ positive	positive negative			Copy of lab result required						
Hepatitis B Titer	positive	b positive b negative			copy of las result required						
Measles, Mumps, Rubella (MMR)											
2 doses of MMR vaccine <b>OR</b> 2 doses of Measles, 2 dos	ses of Mumps an	d 1 dose of Rube	ella; <b>OR</b> serolog	jic proof of imn	nunity for Measles, Mumps and						
Rubella. Choose only one option.  Option 1:											
2 doses of MMR vaccine											
MMR	Date of MMF	Date of MMR Dose #1:		Date of MMR	Dose #2:						
2 doses of MMR vaccine	Must be at 12 months after bi		th or later Must be at		east 1 month after first dose						
	11000 50 00 1	. E monero arcer o	iren or later	i idot be de le	ase I monen area mor asse						
Option 2:											
2 doses of Measles, 2 doses of Mumps and 1 dose of F  Measles (Rubeola)	Date of Dose	ologic proof of imi	Date of Dose	sies, Mumps ai	Or Measles Titer						
2 doses of measles vaccine OR positive titer	Bute of Bose #1.		Date of Dose #2.		or ricusies ricei						
·					☐ positive ☐ negative						
	Must be at 1	Must be at 12 months after Must be a		east 1 month	Date:						
	birth or later		after the firs		Buc.						
			1		Copy of lab result required						
Mumps 2 doses of mumps vaccine OR positive titer	Date of Dose #1:		Date of Dose #2:		Or Mumps Titer						
2 doses of mamps vaccine on positive titel			Must be at least 1 month after the first dose		☐ positive ☐ negative						
	Must be st 1	2 months often			Data						
	birth or later	.2 months after			Date: Copy of lab result required						
	2 6. 14.6.		_		, ,						
Rubella (German Measles)  1 dose of Rubella vaccine OR positive titer	Date of Dose #1:			Or Rubella Ti	ter						
I dose of Rubella vaccine or positive titel				☐ positive	□ negative						
					,						
	Must be at 12 months after birth or late		irth or later	Date:	ate:						
				Copy of lab result required							
				. ,	·						
Meningococcal (A, C, Y, W-135) Required only if under 22 years old, booster dose requ	ired only if doca	was given prior	to 16th hirthda	V							
Meningococcal Vaccine	Date of Dose #	1:	to Total billala		ooster Dose (if applicable):						
☐ Menactra					( !· E).						
☐ Menomune											
☐ Menveo ☐ MenQuadfi											
Other:											

Name	Date of Birth/ First Middle mm dd yy										
Last		TONE	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	ар		Date of Dose:			Date of Booster Dose (if applicable):					
						☐ Tdap ☐ Td					
Varicella (Chicken Pox)											
2 doses of varicella vaccine <b>OR</b> history of disease <b>OR</b> serologic proof of immunity for varicella											
Varicella		Date of Dose # 1:		or History of Disease		Or Varicella Titer					
		Must be 12 months after		Date:		□ positive	□ negative				
		birth or later				Date:					
		Date of Dose # 2	Date of Dose # 2:								
						Copy of lab result required					
Decommended Transminstions (Net Described)											
Recommended 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):						
					12 (2 (2 (2 (2 (2 (2 (2 (2 (2 (2 (2 (2 (2						
HPV	Date of Dose #1:		Date of Dose #2:		Date of Dose #3 (if applicable):						
Meningococcal B	Date of Dose #1:		Date of Dose #2:		Date of Dose #3 (if applicable):						
Meningococcai B	Date of Dose #1:		Date of Dose #2:		Date of Dose #3 (if applicable).						
	☐ Trumenba ☐ Bexsero		☐ Trumenba ☐ Bexsero		☐ Trumenba						
			□ bexsel0								
Polio	Date of most recent dose:										
Flu Vaccine	Date of most recent dose:										
Other (ex: Pneumovax,	Vaccine:	Vaccine:	Vaccine:	Vaccine:	Va	ccine:	Vaccine:				
Yellow Fever, Japanese Encephalitis, Rabies,											
Typhoid, BCG)	Date:	Date:	Date:	Date:	Da	te:	Date:				
Signature of Physician/Medical Provider: Date:											
Signature of Thysician/Hedical From											
Physician/Medical Provider Name (Printed) or Clinic Stamp											
Address											

Phone number: \_\_\_\_\_ Fax Number: \_\_\_\_