



BROWN

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

To return form, student must log in at  
<https://patientportal.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  
A record of an updated 2023–2024 COVID-19 vaccine dose given after September 1, 2023. Please know that some clinical sites will continue to require an updated COVID booster dose as they become available.
- Hepatitis B  
A record 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)  
A record 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  
A record 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  
A record 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 either test, documentation of a negative chest x-ray **and** 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 Last First Middle Date of Birth mm dd yy

REQUIRED IMMUNIZATIONS

COVID-19
A record of an updated 2023-2024 COVID-19 vaccine dose given after September 1, 2023. Please know that some clinical sites will continue to require an updated COVID booster dose as they become available.
COVID-19
Date of Updated 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: Date of Dose #2: Date of Dose #3 (if applicable):
Specify Brand: Specify Brand: 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: Date of MMR Dose #2:
Must be at 12 months after birth or later 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: Date of Dose #2: Or Measles Titer
Must be at 12 months after birth or later Must be at least 1 month after the first dose
positive negative
Date:
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
Must be at 12 months after birth or later Must be at least 1 month after the first dose
positive negative
Date:
Copy of lab result required
Rubella (German Measles)
1 dose of Rubella vaccine OR positive titer
Date of Dose #1: Or Rubella Titer
Must be at 12 months after birth or later
positive negative
Date:
Copy of lab result required

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Last First Middle mm dd yy

### REQUIRED IMMUNIZATIONS

<b>Meningococcal</b> Required for students 22 years old or younger: dose must be given after 16 <sup>th</sup> birthday			
<b>Meningococcal Vaccine</b> • Menactra • Menomune • Menveo • MenQuadfi • Other:	Date of Dose #1:	Date of Booster Dose: (if first dose given before 16th birthday):	
<b>Tdap (Tetanus-Diphtheria-Pertussis)</b> 1 dose of adult Tdap; if last Tdap is more than 10 years old, provide date of last Td or Tdap booster			
<b>Tdap</b>	Date of Dose:	Date of Booster Dose (if applicable): <input type="checkbox"/> Tdap <input type="checkbox"/> Td	
<b>Varicella (Chicken Pox)</b> 2 doses of varicella vaccine or serologic proof of immunity for varicella			
<b>Varicella (Chicken Pox)</b> 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 <input type="checkbox"/> positive <input type="checkbox"/> negative  Date:  Copy of lab result required
<b>Tuberculosis Screening</b> Two skin tests spaced 1-3 weeks apart <b>OR</b> one IGRA test (QuantiFERON Gold /T-SPOT) within 6 months of arrival to Brown. History of LTBI, Positive TB Skin Test, or Positive TB IGRA Blood Test: documentation of a negative chest x-ray and history of latent TB treatment must be submitted			
<b>Tuberculosis Skin Test (PPD)</b> 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:
<b>Or IGRA Testing</b> QuantiFERON Gold or T-SPOT	Date of Test:	Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	Copy of lab result required
<b>Chest X-ray</b> Required only if PPD or IGRA test is positive. Must be within 6 months of arrival at Brown	Date of chest x-ray:	Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Copy of chest x-ray result must be submitted
<b>Latent TB Treatment</b> Required only after a positive TB test/negative chest x-ray	Type of Treatment:	Date Treatment Started:	Date Treatment Completed:

### Additional Immunizations (Not Required)

<b>Hepatitis A</b>	Date of Dose #1:	Date of Dose #2:	Date of Dose #3 (if applicable):
<b>HPV</b>	Date of Dose #1:	Date of Dose #2:	Date of Dose #3 (if applicable):
<b>Meningococcal B</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

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Last First Middle mm dd yy

**Additional Immunizations (Not Required)**

<b>Polio</b>	Date of most recent dose:					
<b>Rabies</b>	Date of Dose #1:	Date of Dose #2:	Date of Dose #3:	<b>Rabies Titer</b> <input type="checkbox"/> positive <input type="checkbox"/> negative Date: Copy of lab result required		
<b>Typhoid</b>	Date of most recent dose: <input type="checkbox"/> Oral <input type="checkbox"/> Injectable					
<b>Other: (ex: Pneumovax, Yellow Fever, Japanese Encephalitis, BCG)</b>	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: \_\_\_\_\_