

# IMMUNIZATION HISTORY FORM

**NOTE:** Student may not participate in Continuing Education programs until this form has been received.

**This form requires a physician's signature.**



Brown University Continuing Education  
Box T  
Providence, Rhode Island 02912-9120  
Tel 401-863-7900 Fax 401-863-3916  
Email: [summer@brown.edu](mailto:summer@brown.edu)  
[www.brown.edu/summer](http://www.brown.edu/summer)

## STUDENT CONTACT INFORMATION Please print

Student's Name \_\_\_\_\_ Gender:  Male  Female  
Home Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Date of Birth (mm/dd/yy) \_\_\_\_\_ Social Security \_\_\_\_\_  
Parent/Guardian Name(s) \_\_\_\_\_  
Parent/Guardian Address (if different from above) \_\_\_\_\_  
Home Phone \_\_\_\_\_ Student cell \_\_\_\_\_  
Parent/Guardian Day Phone \_\_\_\_\_ Evening phone \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Emergency Day phone \_\_\_\_\_ Evening phone \_\_\_\_\_

## THIS SECTION MUST BE COMPLETED AND SIGNED BY YOUR MEDICAL PROVIDER.

Medical Provider: Please document immunization dates below. If documentation is unavailable, re-immunization is a pre-matriculation requirement. Registration will be denied if the required immunizations are not documented. A physical examination is NOT required.

Check here if the student is exempt from immunization requirements due to the medical contraindication or religious beliefs. A signed statement from a Healthcare Provider or Clergy is required.

## REQUIRED IMMUNIZATIONS

1. Tetanus Diphtheria - required within last 10 years: \_\_\_\_\_ OR Tdap \_\_\_\_\_  
DATE DATE

2a. MMR (Measles, Mumps, Rubella) – two MMR doses required: One at least 12 months after birth or later, and one at least one month after the first dose.  
Dose # 1: \_\_\_\_\_ Dose# 2: \_\_\_\_\_  
DATE DATE

OR

2b. If measles, mumps or rubella were given separately, two doses of measles and mumps are required. Please list below with doses.

Dose# 1: \_\_\_\_\_ Dose# 2: \_\_\_\_\_  
DATE DATE

3. Hepatitis B (must have at least first dose): Dose# 1: \_\_\_\_\_ Dose #2: \_\_\_\_\_ Dose #3: \_\_\_\_\_  
DATE DATE DATE

4. Polio – Completed primary series?  YES  NO

5. Chicken Pox -  had disease OR  had vaccine \_\_\_\_\_  
DATE #1 REQUIRED DATE #2 RECOMMENDED

6. Other Vaccines - \_\_\_\_\_

→ SEE REVERSE SIDE

Student Name: \_\_\_\_\_

Name of medical provider (please print) \_\_\_\_\_

Provider's signature \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Date \_\_\_\_\_

**For students enrolled in:**

- CEBI 0903-01 So You Think You Want To Be a Doctor: An Introduction to Medicine CRN: 10067
- CEBI 0909-01 So What's Up Doc? CRN: 10034
- CEBI 0906-01 Exploring Medicine CRN: 10053

The courses listed above have a hospital shadowing component. Current guidelines in the State of Rhode Island for all clinic and/or health care workers require additional and/or more recent immunizations. Please have your medical provider complete the additional information below.

**1. Tuberculin PPD (Mantoux):** Two-step skin tests at least a week apart required regardless of prior BCG inoculation. TEST MUST BE ADMINISTERED AFTER: JANUARY 20, 2012.

PPD two-step given on (date) \_\_\_\_\_ and read on \_\_\_\_\_ results \_\_\_\_\_ mm.

given on (date) \_\_\_\_\_ and read on \_\_\_\_\_ results \_\_\_\_\_ mm.

If positive, chest x-ray taken on \_\_\_\_\_ and copy of x-ray results attached.  
DATE

Name of medical provider (please print) \_\_\_\_\_

Provider's signature \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Date \_\_\_\_\_

**2. Tetanus-Diphtheria-Acellular Pertussis (Tdap):** Single dose required if it has been 2 years or more (prior to July 20, 2010) since the last dose of tetanus-diphtheria (Td) vaccine. If Tdap has been received within the past 10 years (after July 20, 2002) it is not necessary for another dose.

Date of Tdap \_\_\_\_\_ Date of Td \_\_\_\_\_

Name of medical provider (please print) \_\_\_\_\_

Provider's signature \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**RETURN THIS FORM TO:** Brown University Continuing Education  
Box T  
Providence, RI 02912-9120  
Fax: 401-863-3916  
Attn: Forms Coordinator