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**

- **Hepatitis B**
  A record of Hepatitis B vaccine, three doses. If series complete, a quantitative Hepatitis B Surface Antibody titer must be done with a copy of the lab report attached.

- **Influenza**
  A record of Influenza vaccine, received after July 1, 2016. (If unable to receive vaccine prior to arrival on campus, flu vaccine clinics are held at the medical school in the Fall)

- **Measles, Mumps and Rubella**
  A record of two MMR vaccines and positive serological tests for immunity to Measles, Mumps and Rubella. History of disease is not acceptable. A copy of the lab reports must be attached.

- **Meningococcal**
  A record of Meningococcal vaccine if under 22 years old. If first dose was given before the age of 16 years, a booster dose must be recorded.

- **Tetanus/Diphtheria/Pertussis**
  Tdap (Tetanus/Diphtheria/Pertussis) booster within the past 10 years

- **Varicella**
  Positive serological test for immunity to Varicella (chickenpox) only if a history of chickenpox disease. History of disease alone is not acceptable. A copy of the lab report must be attached OR a record of Varicella vaccine, two doses, at least one month apart.

- **Tuberculosis Screening**
  A record one tuberculosis skin tests (PPD) OR one Quantiferon/TB Spot blood test, done within 6 months of arrival at Brown. If there is a positive result to either test, documentation of a negative chest x-ray and prophylaxis therapy must be attached. Two-step PPD testing is required during the first year of medical school. The second PPD test will be performed at Brown.

**Medical Student Additional Immunizations**

- Document any additional immunizations on page 2
# Medical Student Immunizations, Titers & Tuberculosis Screening Record

**Name**

**Date of Birth**  
**mm  dd  yy**

**Address**

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Country</th>
</tr>
</thead>
</table>

### REQUIRED IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Requirement</th>
<th>Dates</th>
<th>Tests (or Other)</th>
</tr>
</thead>
</table>
| **Hepatitis B** | 3 doses and a quantitative titer required | Date of Dose #1:  
Date of Dose #2:  
Date of Dose #3: | ☐ pos  ☐ neg | Attached report required |
| **Influenza** | (Received after July 1, 2016) | Date: | | |
| **MMR (Measles, Mumps, Rubella)** | 2 doses and titers required or individual vaccines and titers as listed below | Date of Dose #1:  
Given at 12 months after birth or later  
Date of Dose #2:  
Given at least 1 month after first dose | ☐ pos  ☐ neg | Attached report required |
| **Measles (Rubella)** | | Date of Dose #1:  
Given at 12 months after birth or later  
Date of Dose #2:  
Given at least 1 month after first dose | ☐ pos  ☐ neg | Attached report required |
| **Mumps** | | Date of Dose #1:  
Given at 12 months after birth or later  
Date of Dose #2:  
Given at least 1 month after the first dose | ☐ pos  ☐ neg | Attached report required |
| **Rubella (German Measles)** | | Date of Dose #1:  
Given at 12 months after birth or later  
Date of Dose #2:  
Given at least 1 month after the first dose | ☐ pos  ☐ neg | Attached report required |
| **Meningococcal Vaccine** | Required if under 22 years old | ☐ Menactra  
☐ Menomune  
☐ Menveo  
Other: | Date of Dose #1: | Date of Booster Dose: Required if dose 1 was given before 16 years old |
| **Tdap (Tetanus-Diphtheria-Pertussis)** | Must be within the past 10 years | Date of Dose: | | |
| **Varicella (Chicken Pox)** | 2 doses required or positive titer | Date of Dose #1:  
Date of Dose #2: | ☐ pos  ☐ neg | Attached report required |

### REQUIRED TITERS

<table>
<thead>
<tr>
<th>Titer Name</th>
<th>Requirement</th>
<th>Dates</th>
<th>Tests (or Other)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### REQUIRED TUBERCULOSIS SCREENING

One skin test (PPD) or an IGRA test (Quantiferon Gold or TB Spot) within 6 months of arrival at Brown.

<table>
<thead>
<tr>
<th>Test Type</th>
<th>Requirement</th>
<th>Dates</th>
<th>Tests (or Other)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PPD</strong></td>
<td>Two-step testing is required during the first year of medical school. The second PPD test will be performed at Brown.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IGRA</strong></td>
<td>Quantiferon Gold or TB Spot</td>
<td></td>
<td>Attach copy of lab report (required)</td>
</tr>
<tr>
<td><strong>Chest X-ray</strong></td>
<td>(Required if PPD or IGRA test is positive. Must be within 6 months of arrival at Brown.)</td>
<td></td>
<td>Attach copy of chest x-ray (required)</td>
</tr>
<tr>
<td><strong>Positive Tuberculosis Test Treatment</strong></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Signature of Healthcare Provider:**  
**Date:**

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

**Address**

**Phone number:**  
**Fax Number:**
# Medical Student Additional Immunizations

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>mm</th>
<th>dd</th>
<th>yy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
<td>Street</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td>Country</td>
<td></td>
</tr>
<tr>
<td><strong>Hepatitis A</strong></td>
<td></td>
<td>Date of Dose #1:</td>
<td>Date of Dose #2:</td>
<td></td>
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<tr>
<td><strong>HPV</strong> (indicate HPV-4 or HPV-9)</td>
<td>Date of Dose #1:</td>
<td>Date of Dose #2:</td>
<td>Date of Dose #3:</td>
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<tr>
<td><strong>Meningococcal B Vaccine</strong> (Trumenba or Bexsero)</td>
<td>Date of Dose #1:</td>
<td>Date of Dose #2:</td>
<td>Date of Dose #3:</td>
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<tr>
<td><strong>Polio</strong></td>
<td></td>
<td>Date of Dose #1:</td>
<td>Date of Dose #2:</td>
<td>Date of Dose #3:</td>
<td>Date of Dose #4:</td>
<td>Date of Dose #5:</td>
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<tr>
<td><strong>Rabies</strong></td>
<td></td>
<td>Date of Dose #1:</td>
<td>Date of Dose #2:</td>
<td>Date of Dose #3:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rabies Titer</strong></td>
<td></td>
<td>Date:</td>
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<tr>
<td><strong>Typhoid</strong></td>
<td></td>
<td>Date:</td>
<td>☐ Oral</td>
<td>☐ Injectable</td>
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<tr>
<td><strong>Other (Pneumovax, Yellow Fever, Japanese Encephalitis)</strong></td>
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</tr>
</tbody>
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Signature of Healthcare Provider: ___________________________ Date: ____________________

Healthcare Provider Name: (Please Print) /Clinic Stamp______________________________

Address ____________________________________________

Phone number: __________________ Fax Number: __________________