

IMMUNIZATION HISTORY FORM

NOTE: Student may not participate in programs until this form has been received.
This form requires a physician's signature.



BROWN

Brown University Continuing Education
 Box T, Providence, Rhode Island 02912-9120
 Tel 401-863-7900 Fax 401-863-3916
www.brown.edu/summer

STUDENT CONTACT INFORMATION Please print

Student is attending: ☐ Pre-College Summer Course(s) ☐ SPARK Science for Middle School Course(s) ☐ Global Program(s) ☐ Sports Camp(s)
 (Check all that apply) ☐ Intensive English Program ☐ TheatreBridge and Playwrights Workshop ☐ Leadership Institute/BELL ☐ Visiting Undergrad

Student's Last Name _____ First Name _____ Gender ☐ Male ☐ Female

Home Address _____ City/State/Zip/Country _____

Date of Birth (mm/dd/yy) _____ Parent/Guardian Name(s) _____

Parent/Guardian Address (if different from above) _____

Home Phone _____ Student Cell Phone _____

Parent/Guardian Day Phone _____ Parent/Guardian Evening phone _____

Parent/Guardian Cell Phone _____ Emergency Contact Name _____

Emergency Contact Relationship _____ Emergency Contact Cell 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 Rhode Island Department of Health Medical Immunization Exemption Certificate or Religious Exemption Certificate is required. Please contact our office to obtain the required forms.

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 one dose of rubella are required. Please list below with doses.

Measles Dose# 1: _____ Measles Dose# 2: _____
 DATE DATE

Mumps Dose# 1: _____ Mumps Dose# 2: _____
 DATE DATE

Rubella Dose# 1: _____
 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 REQUIRED

6. Other Vaccines - _____

Banner ID _____ (office use only)

Student Last Name _____ First 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: 10063**

☐ **CEBI0909-01: So What's up Doc? CRN: 10033**

The course listed above has 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, 2014.

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

given on (date) _____ and read on _____ results _____ mm.

IGRA Blood Test: Quantiferon Gold _____ (date) OR TB Spot _____ (date)

Result: Negative ____ Positive ____ Indeterminate ____

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/County _____

Telephone _____ Date _____

2. Tetanus-Diphtheria-Acellular Pertussis (Tdap): Single dose required. If Tdap has been received within the past 10 years (after July 20, 2004) it is not necessary for another dose. Date of Tdap _____

Name of medical provider (please print) _____

Provider's signature _____

Address _____ City/State/Zip/Country _____

Telephone _____ Date _____

PLEASE RETURN THIS FORM TO: Brown University Continuing Education

Box T

Providence, RI 02912-9120

Fax: 401-863-3916

Attn: Forms Coordinator