BROWN
Division of Pre-College
and Undergraduate Programs

2024 IMMUNIZATION RECORD

Name: _____ Date of Birth: ___/___/___
Last First Middle mm dd yy

Address: _____
Street City State Zip Code Country

REQUIRED PHYSICAL DOCUMENTATION:

Please note: along with required immunizations, you also must also include proof of a physical exam you have undergone in 12 months prior to the beginning of your in-person program (e.g. a physical/yearly appointment or camp/sports physical). Your form will be rejected if you do not include both components (physical record/vaccination record).

Date of last physical/wellness visit/doctor's examination: _____

REQUIRED IMMUNIZATIONS:

Hepatitis B 3 doses of Engerix-B, Recombivax or Twinrix, 2 doses of Heplisav-B (only one dose is required)			
Hepatitis B	Date of Dose #1 (required):	Date of Dose #2:	Date of Dose #3: OR Hepatitis B Titer: ☐ positive ☐ negative Date: *Copy of lab result required*
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. Second dose must be received at least two weeks prior to coming to campus.			
OPTION 1: 2 doses of MMR vaccine			
MMR 2 doses of MMR vaccine	Date of MMR Dose #1: *Must be at least 12 months after birth or later*	Date of MMR Dose #2: *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: *Must be at least 12 months after birth or later*	Date of Dose #2: *Must be at least 1 month after the first dose*	OR Measles Titer: ☐ positive ☐ negative Date: *Copy of lab result required*
Mumps 2 doses of mumps vaccine OR positive titer	Date of Dose #1: *Must be at least 12 months after birth or later*	Date of Dose #2: *Must be at least 1 month after the first dose*	OR Mumps Titer: ☐ positive ☐ negative Date: *Copy of lab result required*
Rubella (German Measles) 1 dose of Rubella vaccine OR positive titer	Date of Dose #1: *Must be at least 12 months after birth or later*	Date of Dose #2: *Must be at least 1 month after the first dose*	OR Rubella Titer: ☐ positive ☐ negative Date: *Copy of lab result required*

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Meningococcal (A, C, Y, W-135/MCV4)

This immunization must include protection against the four meningitis strains noted (ACWY). A vaccination against Meningitis B does not meet this requirement. Examples of acceptable MCV4 vaccines include but are not limited to Menactra, Nimenrix and Menveo.

Brand:	Date of Dose #1:

Tdap (Tetanus-Diphtheria-Pertussis)

1 dose of adult Tdap within last ten years.
Please note that Tdap **is not** denoted as DTP, DTaP, or DTPa. Examples of accepted Tdap vaccines include but are not limited to brands such as Adacel and Boostrix.

Tdap	Date of Dose:

Varicella (Chicken Pox)

2 doses of varicella vaccine **OR** history of disease OR serologic proof of immunity for varicella

Varicella	Date of Dose #1: *Must be at least 12 months after birth or later* Date of Dose #2:	**OR** History of Disease Date:	OR Varicella Titer: ☐ positive ☐ negative Date: *Copy of lab result required*

Signature of Physician/Medical Provider: _____ Date: _____

Physician/Medical Provider Name (printed) or Clinic Stamp: _____

Address: _____

Phone Number: _____ Fax Number: _____