

# IMMUNIZATION HISTORY FORM



Brown University, Box 1946  
Providence, Rhode Island 02912-9120  
Tel 401-863-3100 Fax 401-863-3955  
Email: [conference\\_services@brown.edu](mailto:conference_services@brown.edu)  
[www.brown.edu/conferenceservices](http://www.brown.edu/conferenceservices)

## 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: \_\_\_\_\_

**RETURN THIS FORM TO:**

Brown University  
ATTN: Conference Services  
Box 1946  
Providence, RI 02912-9120  
Fax: 401-863-3955