Banner ID_____ (office use only)

IMMUNIZATION HISTORY FORM

NOTE: Student may not participate in 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
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: _____ (DATE) OR Tdap _____ (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: _____ (DATE) Dose# 2: _____ (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: _____ (DATE) Measles Dose# 2: _____ (DATE)
Mumps Dose# 1: _____ (DATE) Mumps Dose# 2: _____ (DATE)
Rubella Dose# 1: _____ (DATE)

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

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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