

Brown Summer Programs Immunization History Form

Full legal name of student _____ Date _____
FAMILY, FIRST, MIDDLE

Date of birth _____ Age _____ Sex _____

Home address _____

_____ Country _____ Phone _____

THIS SECTION MUST BE COMPLETED AND SIGNED BY YOUR MEDICAL PROVIDER.

Document immunization dates below. We will also accept school immunization records, health department or national health records. 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. A copy of the student's immunization record may be sent to us by the physician, parent, or school.

- Mark here if the student is exempt from immunization requirements due to medical contraindication or religious beliefs. A signed statement from a Health Care Provider or Clergy is required.

REQUIRED IMMUNIZATIONS

TETANUS DIPHTHERIA: required within the last 10 years: _____
DATE

TUBERCULIN PPD (MANTOUX): required regardless of prior BCG inoculation within past 12 months
Result: _____ mm on _____ (date) If positive, chest x-ray required. _____ (date)

Complete A or B

A. MMR (MEASLES, MUMPS, RUBELLA): One at 12 months after birth or later and one at least one month after the first dose

has had two MMR doses: Dose #1 _____ Dose #2 _____
DATE DATE

or

B. MEASLES: One at 12 months after birth or later and one at least one month after the first dose

has had TWO measles immunizations: Dose #1 _____ Dose #2 _____;
DATE DATE

or

has had measles diagnosed and documented by a physician; or

has had a measles test showing immunity, titer _____
DATE

and

RUBELLA (GERMAN MEASLES): Any person, regardless of age

has been immunized against rubella on or after the age of 12 months _____; or
DATE

has had a rubella test showing immunity, titer _____
DATE

RECOMMENDED IMMUNIZATIONS

HEPATITIS B: Dose #1 _____ Dose #2 _____ Dose #3 _____
DATE DATE DATE

POLIO: Completed primary series: yes no

CHICKEN POX: had disease or had vaccine _____
DATE

OTHER VACCINES: _____

Name of medical provider (please print) _____

Provider's signature _____

Address _____

Telephone (_____) _____ Date _____