



BROWN

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Assistant Director of Operations
and Administration
Health Services
450 Brook St.
Providence, RI 02906
401 863-3953
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Dear Gateways Program Student:

Welcome to Brown! Your first interaction with Health Services will be the health and immunization requirements that you must meet as a Gateways Program student. This will begin our partnership in caring for your health while you are enrolled at Brown.

All forms and detailed instructions are available on our website at <https://www.brown.edu/campus-life/health/services/medical-student-health-requirement>

**** Please note, students in the Gateways Program have the same forms, immunization and testing requirements as medical students. These requirements are more extensive than those for undergraduate and graduate students. ****

Gateways Student Forms, Immunizations, Titers and Tuberculosis Screening Requirements:

- Print the Medical Student Immunizations, Titers & Tuberculosis Screening Record (attached) and review the requirements for immunizations and serologic testing. Contact your medical provider for form completion and further immunizations and testing if indicated. We will also accept official immunization records from your provider, previous school, or health department.
Rhode Island state law **requires** all students to provide written documentation of their immunizations. Brown University requires serologic testing for all medical students. Two-step tuberculosis screening is required within the past 6 months, if indicated.
- Log onto your patient portal at <https://patientportal.brown.edu>
 - Select “Forms” and complete the following:
 - Health History Form
 - Respiratory Medical Evaluation Form
 - Authorization for Medical Care and Treatment
 - Select “Upload” to submit your immunization records and serology lab results
 - Select “Immunizations” to enter the dates of your immunizations, titer, and TB testing
- If you waived and will not be participating in the Brown Student Health Insurance plan, make a copy of your health insurance card and your pharmacy prescription benefits card.
 - Log onto your patient portal at <https://patientportal.brown.edu>
 - Select “Upload” to submit your Medical Insurance Card or Prescription Benefit Card, if applicable upload of copy of both sides of your card(s)

Information about Health Services

Brown Health Services is a wellness center as well as a place for students to come when they are ill. A staff of physicians, nurse practitioners, physician assistants and nurses provide medical care by appointment. Call ahead and get an appointment the same day or at a more convenient time. Limited evening and weekend appointments are available for medical students. Nursing advice is available 24/7 by calling 401-863-3953.

Medications

A pharmacy is located at Health Services that carries prescription medications, as well as over the counter products. The pharmacy can fill your prescription as long as we have a written, electronic, or telephone prescription from your provider or we can transfer refills from the pharmacy that originally filled the prescription. You may also be seen by a provider at Health Services to obtain a prescription.

Confidential Medical Records

Health Services records are confidential and are not released (e.g. to parents or faculty) without written authorization from the student. There are exceptions when the release of specific information without a student's expressed consent is necessary in emergencies or is required by law.

Health Services Fee

Full-time students are billed a mandatory Health Services fee that covers use of the facility and its services. (This fee is *separate* from the student health insurance charge, and cannot be waived.) The fee covers unlimited visits to Health Services during the academic year. Students are encouraged to contact Health Services for their healthcare needs.

Health Insurance

Health insurance is required for services not covered by the health fee (lab, x-ray and pharmacy) or to access healthcare in the community. Therefore, all registered students will be automatically enrolled in the 2022-2023 Student Health Insurance Plan (SHIP) for coverage effective 8/1/2022 to 8/15/2023. Participation in SHIP is mandatory, however, students may waive enrollment in SHIP if they are covered by a comparable health insurance plan. More information on SHIP is available at this website: <https://www.brown.edu/about/administration/insurance/insurance-students>

If you have any questions, please feel free to contact the nursing at nursing@health.brown.edu.

Best regards,

Christine Farland, MHA, BSN, RN

Assistant Director of Operations and Administration

Brown University Health Services (www.brown.edu/health)



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Medical Student Required Immunizations, Titers & Tuberculosis Screening

Brown University requires all medical students to provide written documentation of the following on the Medical Student Immunization, Titers & Tuberculosis Screening Record:

Medical Student Immunization, Titers & Tuberculosis Screening Record

- COVID-19
A record of a one or two dose COVID-19 vaccine series and a booster dose at least 5 months after series completion.
- Hepatitis B
A record of a Hepatitis B vaccine series. After series completion, a **quantitative** Hepatitis B Surface Antibody titer must be completed, a copy of the lab report must be submitted.
- Measles, Mumps and Rubella (MMR)
A record of two (2) MMR vaccines **OR** two (2) doses of Measles, two (2) doses of Mumps and one (1) dose of Rubella; **OR** serologic proof of immunity for Measles, Mumps and Rubella. History of disease is not acceptable. A copy of the lab reports must be submitted.
- Meningococcal A, C, Y, W-135
If you are under 22 years old, at least one dose is required between the ages of 16 and 22 years.
- Tetanus/Diphtheria/Pertussis (Tdap)
One dose of adult Tdap. If the last Tdap dose is more than 10 years old, then a Tetanus Diphtheria (Td) or Tdap booster is required.
- Varicella
A record of two Varicella vaccines **OR** if a history of chickenpox disease, serologic proof of immunity for Varicella (chickenpox) is required. History of disease alone is not acceptable. A copy of the lab report must be submitted.
- Tuberculosis Screening
A record of **two** tuberculosis skin tests (TST) – spaced 1-3 weeks apart **OR** one IGRA blood test (Quantiferon Gold/T-SPOT), completed **within 6 months** prior to arrival at Brown. If there is a positive result to either test, documentation of a negative chest x-ray **and** history of latent TB treatment must be submitted.
- Influenza
The Influenza vaccine will be required during the fall of 2022. Flu vaccine clinics will be held at the medical school in the fall.
- Recommended, Not Required Vaccines
Document any additional immunizations on page 2 of the immunization record form



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Medical Student Immunizations, Titters & Tuberculosis Screening Record

Name _____ Date of Birth _____
Last First Middle mm dd yy

REQUIRED IMMUNIZATIONS

COVID-19 A record of a one or two dose COVID-19 vaccine series AND a booster dose if >5 months after initial series completion			
COVID-19	Date of Dose #1: <input type="checkbox"/> Janssen (J & J) <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> Other (specify brand)	Date of Dose #2 (if applicable): <input type="checkbox"/> Janssen (J & J) <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> Other (specify brand)	Date of Booster dose: if >5 months after series completion: <input type="checkbox"/> Janssen (J & J) <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> Other (specify brand)
Hepatitis B 3 doses of Engerix-B, Recombivax or Twinrix, OR 2 doses of Heplisav-B, followed by a QUANTITATIVE Hepatitis B Surface Antibody (titer) drawn 4-8 weeks after the last dose. If negative titer complete a second Hepatitis B series followed by a repeat titer.			
Hepatitis B 3-dose vaccines (Engerix-B, Recombivax, Twinrix)	Date of Dose #1:	Date of Dose # 2:	Date of Dose #3:
Or Hepatitis B 2-dose vaccine (Heplisav-B)	Date of Dose #1:	Date of Dose # 2:	
<i>And</i> Quantitative Hepatitis B Titer	<input type="checkbox"/> positive <input type="checkbox"/> negative	Date:	Copy of lab result required
Secondary Hepatitis B Series Only if negative titer after primary series	Date of Dose #1: Specify Brand:	Date of Dose # 2: Specify Brand:	Date of Dose #3 (if applicable): Specify Brand:
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.			
Option 1: 2 doses of MMR vaccine			
MMR 2 doses of MMR vaccine	Date of MMR Dose #1: Must be at 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 12 months after birth or later	Date of Dose #2: Must be at least 1 month after the first dose	Or Measles Titer <input type="checkbox"/> positive <input type="checkbox"/> negative Date: Copy of lab result required
Mumps 2 doses of mumps vaccine OR positive titer	Date of Dose #1: Must be at 12 months after birth or later	Date of Dose #2: Must be at least 1 month after the first dose	Or Mumps Titer <input type="checkbox"/> positive <input type="checkbox"/> 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 12 months after birth or later	Or Rubella Titer <input type="checkbox"/> positive <input type="checkbox"/> negative Date: Copy of lab result required	

Name _____ Date of Birth _____
 Last First Middle mm dd yy

REQUIRED IMMUNIZATIONS

Meningococcal Required only if under 22 years old, booster dose required only if dose was given prior to 16th birthday			
Meningococcal Vaccine <input type="checkbox"/> Menactra <input type="checkbox"/> Menomune <input type="checkbox"/> Menveo <input type="checkbox"/> Other:	Date of Dose #1:	Date of Booster Dose: (if applicable)	
Tdap (Tetanus-Diphtheria-Pertussis) 1 dose of adult Tdap; if last Tdap is more than 10 years old, provide date of last Td or Tdap booster			
Tdap	Date of Dose:	Date of Booster Dose (if applicable):	
Varicella (Chicken Pox) 2 doses of varicella vaccine or serologic proof of immunity for varicella			
Varicella (Chicken Pox) 2 doses required or positive titer	Date of Dose # 1: Must be given 12 months after birth or later	Date of Dose # 2: Must be at least 1 month after the first dose	Or Varicella Titer <input type="checkbox"/> positive <input type="checkbox"/> negative Date: Copy of lab result required
Tuberculosis Screening Two skin tests spaced 1-3 weeks apart OR one IGRA test (QuantiFERON Gold /T-SPOT) within 6 months of arrival to Brown. History of LTBI, Positive TB Skin Test, or Positive TB IGRA Blood Test: documentation of a negative chest x-ray and history of latent TB treatment must be submitted			
Tuberculosis Skin Test (PPD) 2 skin tests 1-3 weeks apart within 6 months prior to arrival at Brown.	Date of Test #1:	Date of Read #1:	Result in mm #1:
	Date of Test #2:	Date of Read #2:	Result in mm #2:
Or IGRA Testing QuantiFERON Gold or T-SPOT	Date of Test:	Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	Copy of lab result required
Chest X-ray Required only if PPD or IGRA test is positive. Must be within 6 months of arrival at Brown	Date of chest x-ray:	Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Copy of chest x-ray result must be submitted
Latent TB Treatment Required only after a positive TB test/negative chest x-ray	Type of Treatment:	Date Treatment Started:	Date Treatment Completed:

Additional Immunizations (Not Required)

Hepatitis A	Date of Dose #1:	Date of Dose #2:	Date of Dose #3 (if applicable):
HPV	Date of Dose #1:	Date of Dose #2:	Date of Dose #3 (if applicable):
Meningococcal B	Date of Dose #1: <input type="checkbox"/> Trumenba <input type="checkbox"/> Bexsero	Date of Dose #2: <input type="checkbox"/> Trumenba <input type="checkbox"/> Bexsero	Date of Dose #3 (if applicable): <input type="checkbox"/> Trumenba

Name _____ Date of Birth _____
 Last First Middle mm dd yy

Additional Immunizations (Not Required)

Polio	Date of most recent dose:					
Rabies	Date of Dose #1:	Date of Dose #2:	Date of Dose #3:	Rabies Titer <input type="checkbox"/> positive <input type="checkbox"/> negative Date: Copy of lab result required		
Typhoid	Date of most recent dose: <input type="checkbox"/> Oral <input type="checkbox"/> Injectable					
Other: (ex: Pneumovax, Yellow Fever, Japanese Encephalitis, BCG)	Vaccine: Date:	Vaccine: Date:	Vaccine: Date:	Vaccine: Date:	Vaccine: Date:	Vaccine: Date:

Signature of Healthcare Provider: _____ Date: _____

Healthcare Provider Name: (Please Print) /Clinic Stamp _____

Address _____

Phone number: _____ Fax Number: _____