

Yale University Student Immunization and TB Testing History Form

THIS FORM IS REQUIRED AND WILL BE READ ELECTRONICALLY. DATES MUST BE ENTERED ON THIS FORM. DO NOT ATTACH A SEPARATE VACCINATION RECORD. All dates must in MM-DD-YYYY format.

Last Name Tester 4	First Name	Date of Birth:	2002 Chosen N	lame
gtestery Osbcglobal. net	Phone 203 5551212	Sex Assigned at Birth	Gender Identity	Pronouns H ₁
Department/Program of Study at Yale (Check one)				
☑Undergraduate * ☑Graduate * ☑Summer	* School of Medicine ± Scho	ol of Nursing ± APhy	sician Associate Pro	ogram ±

Part 1: Required for all Students							
			IMMUNIZATIO	N HISTORY			
1. MEASLES, MUMPS, RUBELLA (MMR) IMMUNITY – * ± Required for all students							
Option 1	 First dose must birthday; secondays from firs If above not satisfies 	ips, Rubella (MMR) Vaccination must be given on or after your first econd dose must be at least 28 first dose. of satisfied, obtain a booster and given, or complete Option 2.		Dose #1: <u>04</u> - <u>02</u> MM DD		Dose #2: <u>Q5</u> - <u>Q2</u> - <u>2003</u> MM DD YYYY	Booster (if indicated): Ob-O2-2010 MM DD YYYY
Option 2	In lieu of proof of above, a titer sho to each individua acceptable altern vaccination. LAB RESULTS MUST	*If not immune, you are required to receive a booster and repeat the titer. *If not immune, you are required to receive a booster and repeat the titer. *If not immune, you are required to receive a booster and repeat the titer.					
2. VARICELLA IMMUNITY - * ± Required for all students born after 1979							
Option 1	Option 1 Varicella Vaccination – first dose must be given on or after your first birthday to be accepted.		Dose #1 04-15 MM DD	2003 YYYY		-15-2003 A DD YYYY	
Option 2	In lieu of proof of vaccination above, a titer showing immunity is an acceptable alternative to vaccination. Required: Attach lab results		Varicella Titer Result: *If not immune, you are Immune* 02-0 -2024 required to receive a booster and repeat the titer.				
Option 3 An incidence of disease will take the place of a vaccine requirement. (Must be filled in by an MD/DO/APRN/PA-C.)		Varicella disease: O2 O1 -2020 MM DD YYYY					
3. MENINGOCOCCAL Vaccination — * ± Required of all undergraduate and graduate students living in university dormitories							
Meningitis Vaccine (MCV 4) Must cover strains A, C, Y, W-135 (Menactra, MenQUADfi Menveo, Nimenrix, or Penbraya) Date: MM DD YYYY Vaccination MUST have been given years of your first day of class at Y		The state of the s	Exceptions to requirement: A I will not be living in university-owne dormitories.				

Student Name: Gregg Tester4

Part 2: Required for all Health Professions Students

4. TUBERCULOSIS (TB) — ± Required for Health Professions Students — All other students to complete TB Risk Assessment Form (in packet)						
STEP 1: TB Blood Test/IGR	RA OR TB Skin Test (PPD) STEP 2: DO NOT COMPLETE UNLESS <u>POSITIVE</u> TB SKIN TEST OF TB BLOOD TEST					
Date: O -O - 2023 MM DD YYYY RESULT: A NEG D POS* Required: Attach lab results.	06-15-2023		CHEST XRAY Required if past or current positive TB skin or blood test. Not required if completed medication treatment for TB. Chest X-ray Date: Ol-Ol-2024 MM DD YYYY Normal Abnormal		TB TREATMENT A Latent TB Infection Active TB Infection Date(s): 06-30-2023 MM DD YYYY List Medication(s): None	
5. COVID-19 VACCINATION Please submit documents					for all other students. 024 updated formulation.	
PRIMARY DOSE #1		PRIMARY DOSE #	2 (skip if J&J vac	ccine) COVID-1	COVID-19 updated 2023-2024 dose	
Date: O3-15-2021 MM DD YYYY M Moderna Pfizer Johnson & Johnson/Janssen Novavax Other WHO approved Name:		Date: OH - 15 - 2021 MM DD YYYY M Moderna Pfizer Novavax Other WHO approved Name: Sam		Ø Pfize Ø Nova Name:	MM DD YYYY M Moderna Pfizer Novavax	
6. Hepatitis B Immunity – Documentation of a COM						
Hepatitis B Vaccine (enter name)	(enter name)		Date of Dose #3 (if applicable): -2022 YYYY Date of Dose #3 (if applicable): 05-61-2022 MM DD YYYY		Hep B Surface Antibody Titer (QUANTITATIVE) O6 - O1 - 2023 MM DD YYYY Result: 12 IU / sc Immune Not Immune	
7. TETANUS-DIPTHERIA-PERTUSSIS (Tdap) — ± Required for Health Professions Students — Not required for all other students.						
Only Tdap is accepted within the past 10 years Date of most recent Tdap dose: Olivia						
Influenza (Flu) I Vaccination						

Student Name: Gregg Testery

Part 3: Recommended vaccines based on personal history – (please record if applicable)

OTHER VACCINES - NOT required					
Hepatitis A Vaccine	Date of Dose #1:	Date of Dose #2:			
	CL -61 -2006 MM DD YYYY	03-01-2006 MM DD YYYY			
HPV Vaccine	A HPV 4	Date of Dose #1: Date of Dose #2: Date of Dose #3:			
	™ HPV 9	01-01-2004 03-01-2004 MM DD YYYY MM DD YYYY MM DD YYYY			
Meningococcal Serogroup B	Bexsero, 2 doses Trumenba, 3 doses	Date of Dose #1: Date of Dose #2: Date of Dose #3 (if			
Vaccine		OL -01 - 2004 O3 - 01 - 2004 Trumenba): 05 - 01 - 2004 MM DD YYYY MM DD YYYY			
Yellow Fever	Yellow Fever Stamaril	Date of Dose: 06-01-2010 MM DD YYYY			
Typhoid	Date of Dose:				
	66 - 01 - 2010 MM DD YYYY				

Part 4: Medical Provider Certification of the Above Information

Medical Provider Name Dr Ruben stein	Medical Provider Signature	02_20_204 Month Day Year
Address (Include city and state) 5 Request Pl. West brook,		ohone 03 555 1212
State or Country of Licensure / License #	Fax 24	03555 1213

Form must be stamped or Signed by Medical Provider