

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: F	Required for all	Students				l l	
			IMMUNIZATIO	N HISTORY			
1. MEASLE	S, MUMPS, RUBEL	LA (MMR) IMM	UNITY – * ± Require	ed for all stud	lents		
Option 1	 Measles, Mumps, Rubella (MMR) Vaccination First dose must be given on or after your first birthday; second dose must be at least 28 days from first dose. If above not satisfied, obtain a booster and enter date 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 vaccination above, a titer showing immunity to each individual disease is an acceptable alternative to vaccination. LAB RESULTS MUST BE ATTACHED In lieu of proof of vaccination Measles Titer Result: In Immune* O2-01-2024 MM DD YYYY Mumps Titer Result: In Immune* O2-01-2024 Ammune* O2-01-2024 A						
						por version and an experience of the second	
Option 1	n 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 required to receive a booster and repeat the titer					
Option 3	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							
Must cover (Menactra,	Vaccine (MCV 4) strains A, C, Y, W-135 MenQUADfi Menveo, rix, or Penbraya)	MM I Vaccination MI	2019 DD YYYY UST have been give irst day of class at Y	The state of the s) Mai	ons to requiremen will not be living in itories.	nt: n university-owned

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/IGF	RA OR T	B Skin Test (PPD)	STEP 2: DO NOT O	OMPLETE UNI	ESS <u>POSITIVE</u> TB SKIN TEST OR	
Date: O -O - 202 MM DD YYYY RESULT: A NEG D POS ² Required: Attach lab results.	06 - 1 MM DD YYYY Date read: 06 - 2 MM D NEG POS* Interpretation: A		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 VACCINATIO Please submit docum					for all other students. 024 updated formulation.	
PRIMARY DOSE #1		PRIMARY DOSE #	2 (skip if J&J vaccir	e) 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: MM DD YYYY Moderna Pfizer Novavax Other WHO approved Name: Sam		Ø Pfize Ø Nova Name:	<u>LO</u> - <u>LO</u> - <u>202</u> 3 MM DD YYYY	
6. Hepatitis B Immunity – ± Required for Health Professions Students – Not required for all other students. Documentation of a COMPLETE series of Hepatitis B vaccination AND quantitative antibody titer.						
Hepatitis B Vaccine (enter name) Ol -Ol -20 MM DD YYYY		22 03- <u>01</u>	applicable): -2022		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: MM DD YYYY 8. INFLUENZA VACCINATION: ± Required for Health Professions Students, documentation to be submitted during flu season. Recommended but not required for all other students.						
Influenza (Flu) Vaccination Date of Influenza Vaccination: O - 13 - 2013 MM DD YYYY Must be between September and March of CURRENT academic year						

Student Name: Grage Testery

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

OTHER VACCINES - NOT req	uired			
Hepatitis A Vaccine	Date of Dose #1: (A - 61 - 2006 MM DD YYYY	Date of Dose #2: 03-01-2006 MM DD YYYY		
HPV Vaccine	AL HPV 4 AL HPV 9	Date of Dose #1: OL -OL - 200# MM DD YYYY	Date of Dose #2: O3 -O1 - 2004 MM DD YYYY	Date of Dose #3: 05 -01 - 2004 MM DD YYYY
Meningococcal Serogroup B Vaccine	Bexsero, 2 doses Trumenba, 3 doses	Date of Dose #1: OL -OL - 2004 MM DD YYYY	Date of Dose #2: 03 -01 -2004 MM DD YYYY	Date of Dose #3 (if Trumenba): <u>25</u> <u>6(</u> <u>2004</u> MM DD YYYY
Yellow Fever	Yellow Fever Stamaril	Date of Dose: 06-01-200 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	Date 02-20-2024 Month Day Year
Address (Include city and state) 5 Request Pl. West brook,		Telephone 203 555 1212
State or Country of Licensure / License #		Fax 203555 1213
Cl 1234567		200000 12 3

Form must be stamped or Signed by Medical Provider

Stamp	Signature	