

## 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 <sub>1</sub>		
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. MEASLE	1. MEASLES, MUMPS, RUBELLA (MMR) IMMUNITY – * ± Required for all students						
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	above, a titer showing immunity to each individual disease is an acceptable alternative to vaccination.  LAB RESULTS MUST BE ATTACHED  Measles Titer Result: Immune* 12-01-2024 MM DD YYYY  Mumps Titer Result: Immune* 12-01-2024 MM DD YYYY  *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	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			*If not immune, you are    Immune* 02-0 -2024 required to receive a booster and repeat the titer.			
Option 3	ption 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 $-*\pm$ 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:  Ol-Ol-2019  MM DD YYYY  Vaccination MUST have been given years of your first 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	t/IGRA OR TB Skin Test (PPD)		STEP 2: DO NOT COMPLETE UNLESS <u>POSITIVE</u> TB SKIN TEST OR TB BLOOD TEST			
Date: O -O - 202 MM DD YYYY  RESULT: A NEG D POS <sup>2</sup> Required: Attach lab results.	O6 - 15 - 2013 MM DD YYYY  Date read: O6 - 30 - 2013  MM DD YYYY  Interpretation: A NEG		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 VACCINATIO  Please submit docum					for all other students. 024 updated formulation.	
PRIMARY DOSE #1		PRIMARY DOSE #	2 (skip if J&J vaccin	e) COVID-1	VID-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 — ± Required for Health Professions Students — Not required for all other students.  Documentation of a COMPLETE series of Hepatitis B vaccination AND <u>quantitative</u> antibody titer.						
Hepatitis B Vaccine (enter name)  Output  Date of Dose #1		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:  Olivia						
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 Testary

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:		
	<u> </u>	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	Trumenba, 3 doses	OL -01 - 2004 O3 - 01 - 2004 Trumenba): 05 - 01 - 2004 MM DD YYYY MM DD YYYY		
Yellow Fever	X Yellow Fever	Date of Dose:		
	Stamaril	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	Date 02_20_2024 Month Day Year
Address (Include city and state)  5 Regust Pl. West brook,	Telephone 203	555 1212
State or Country of Licensure / License #	Fax 203 3	555 12 [3

Form must be stamped or Signed by Medical Provider

Dr. T. SINGH (SETHI)  B.Sc. M.B.B.S., (Pune) F.C.G.P.  Regn No. 30888 (Bombay)  JAS CLINIC	Stamp		Signature
3100 No. 311/37-D. Chandisorth-160036		R.Sc. M.B.B.S., (Pune) F.C.G.P. Regn No. 30828 (Bombay)	