

## 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. MEASLES, MUMPS, RUBELLA (MMR) IMMUNITY – * ± Required for all students							
Option 1	<ul> <li>First dose must birthday; secondays from firs</li> <li>If above not satisfies</li> </ul>	ps, Rubella (MMR) Vaccination must be given on or after your first econd dose must be at least 28 first dose. t 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  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:  Ol-Ol-2019  MM DD YYYY  Vaccination MUST have been giver years of your first day of class at Y		The state of the s	Exceptions to requirement:  \[ \int \]  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	A 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: Grage Testory

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	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

