

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. 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	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 Measles Titer Result: Is Immune* 02-01-2024 MM DD YYYY Rubella Titer Result: Is Immune* 02-01-2024 MM DD YYYY Rubella Titer Result: Is Immune* 02-01-2024 receive a booster and repeat the titer.						
2. VARICELLA IMMUNITY – * ± Required for all students born after 1979							
Option 1	tion 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	ption 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	on 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: 02-01-2020 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) 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 COMPLETE UNLESS <u>POSITIVE</u> TB SKIN TEST OR TB BLOOD TEST			
	MM DD YYYY RESULT: A NEG Dos* Required: Attach lab Date read: MM Interpretation:		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	9 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 Moderna Pfizer Novavax Other WHO approved Name: Name:		Ø Pfize Ø Nova Name:	MM DD YYYY M Moderna Prizer 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)	OdOl <u>20</u> MM DD YYYY	22 03- <u>01</u>	applica -2022 <u>0</u> 5		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: 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:			
	QL -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:			
	Ø 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	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	02-20-2024 Month Day Year
Address (Include city and state) 5 Request Pl. West brook,	Telephor 203	ne 3 555 1212
State or Country of Licensure / License #	Fax 203	555 1213

Form must be stamped or Signed by Medical Provider

Stamp	Signature	
9	Hazel V. Pomada, R.N.	
	PRC License No 0876932	
	REGISTERED NURSE	