Yale HEALTH

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https://healthontrack.yale.edu

# 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 | First Name | Date of Birth: MM DD YYYY | Chosen Name |
|---|---|---|---|
| Tester4 | Gregg | 04-02-2002 | Gregg |

| E-mail | Phone | Sex Assigned at Birth | Gender Identity | Pronouns |
|---|---|---|---|---|
| gtester4@sbcglobal.net | 203 5551212 | M | M | Him |

**Department/Program of Study at Yale** (Check one)
☒ Undergraduate * ☒ Graduate * ☒ Summer * ☒ School of Medicine ± ☒ School of Nursing ± ☐ Physician Associate Program ±

## Part 1: Required for all Students

### IMMUNIZATION HISTORY

**1. MEASLES, MUMPS, RUBELLA (MMR) IMMUNITY – * ± Required for all students**

| | | Dose #1: | Dose #2: | Booster (if indicated): |
|---|---|---|---|---|
| **Option 1** | Measles, Mumps, Rubella (MMR) Vaccination<br>• First dose must be given on or after your first birthday; second dose must be at least 28 days from first dose.<br>• If above not satisfied, obtain a booster and enter date given, or complete Option 2. | 04-02-2003 MM DD YYYY | 05-02-2003 MM DD YYYY | 06-02-2010 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.<br>LAB RESULTS MUST BE ATTACHED | Measles Titer Result: ☒ Immune* 02-01-2024 MM DD YYYY<br>Mumps Titer Result: ☒ Immune* 02-01-2024 MM DD YYYY<br>Rubella Titer Result: ☒ Immune* 02-01-2024 MM DD YYYY | *If not immune, you are required to receive a booster and repeat the titer. |

**2. VARICELLA IMMUNITY – * ± Required for all students born after 1979**

| | | Dose #1 | Dose #2: |
|---|---|---|---|
| **Option 1** | Varicella Vaccination – first dose must be given on or after your first birthday to be accepted. | 04-15-2003 MM DD YYYY | 06-15-2003 MM DD YYYY |

| | | | |
|---|---|---|---|
| **Option 2** | In lieu of proof of vaccination above, a titer showing immunity is an acceptable alternative to vaccination.<br>**Required:** ☐ Attach lab results | Varicella Titer Result:<br>☒ Immune* 02-01-2024 MM DD YYYY | *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: 02-01-2020 MM DD YYYY | |

**3. MENINGOCOCCAL Vaccination – * ± Required of all undergraduate and graduate students living in university dormitories**

| | | |
|---|---|---|
| Meningitis Vaccine (MCV 4)<br>Must cover strains A, C, Y, W-135 (Menactra, MenQUADfi Menveo, Nimenrix, or Penbraya) | Date: 01-01-2019 MM DD YYYY<br>Vaccination MUST have been given WITHIN 5 years of your first day of class at Yale. | **Exceptions to requirement:**<br>☒ I will not be living in university-owned dormitories. |

Yale Student Immunization and TB History Form

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/IGRA OR TB Skin Test (PPD) | | STEP 2: DO NOT COMPLETE UNLESS POSITIVE TB SKIN TEST OR TB BLOOD TEST | |
|---|---|---|---|
| ☒ QuantiFERON ☒ T-Spot<br>Date: 01-01-2023 (MM DD YYYY)<br>RESULT: ☒ NEG ☒ POS*<br>**Required: ☒ Attach lab results.** | Date planted: 06-15-2023 (MM DD YYYY)<br>Date read: 06-20-2023 (MM DD YYYY)<br>Interpretation: ☒ NEG ☒ POS*<br>mm of induration: 9 | **CHEST XRAY**<br>Required if past or current positive TB skin or blood test. Not required if completed medication treatment for TB.<br>Chest X-ray Date: 01-01-2024 (MM DD YYYY)<br>☒ Normal ☒ Abnormal | **TB TREATMENT**<br>☒ Latent TB Infection<br>☒ Active TB Infection<br>Date(s): 06-30-2023 (MM DD YYYY)<br>List Medication(s): None |

**5. COVID-19 VACCINATION – ± Required for Health Professions Students – Strongly encouraged for all other students.**
- **Please submit documentation of prior vaccine doses AND at least one (1) dose of 2023-2024 updated formulation.**

| PRIMARY DOSE #1 | PRIMARY DOSE #2 (skip if J&J vaccine) | COVID-19 updated 2023-2024 dose |
|---|---|---|
| Date: 03-15-2021 (MM DD YYYY)<br>☒ Moderna<br>☒ Pfizer<br>☒ Johnson & Johnson/Janssen<br>☒ Novavax<br>☒ Other WHO approved<br>Name: Bob | Date: 04-15-2021 (MM DD YYYY)<br>☒ Moderna<br>☒ Pfizer<br>☒ Novavax<br>☒ Other WHO approved<br>Name: Sam | Date: 10-13-2023 (MM DD YYYY)<br>☒ Moderna<br>☒ Pfizer<br>☒ Novavax<br>Name: Test |

**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) | Date of Dose #1: | Date of Dose #2: | Date of Dose #3 (if applicable): | Hep B Surface Antibody Titer (QUANTITATIVE) |
|---|---|---|---|---|
| | 01-01-2022 (MM DD YYYY) | 03-01-2022 (MM DD YYYY) | 05-01-2022 (MM DD YYYY) | 06-01-2023 (MM DD YYYY)<br>Result: 12 IU / sc<br>☒ 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: 02-10-2024 (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: 10-13-2013 (MM DD YYYY)<br>Must be between September and March of CURRENT academic year |
|---|---|

Student Name: Gregg Tester4

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

| OTHER VACCINES - NOT required | | | | |
|---|---|---|---|---|
| **Hepatitis A Vaccine** | Date of Dose #1: 01-01-2006 MM DD YYYY | Date of Dose #2: 03-01-2006 MM DD YYYY | | |
| **HPV Vaccine** | ☒ HPV 4<br>☒ HPV 9 | Date of Dose #1: 01-01-2004 MM DD YYYY | Date of Dose #2: 03-01-2004 MM DD YYYY | Date of Dose #3: 05-01-2004 MM DD YYYY |
| **Meningococcal Serogroup B Vaccine** | ☒ Bexsero, 2 doses<br>☐ Trumenba, 3 doses | Date of Dose #1: 01-01-2004 MM DD YYYY | Date of Dose #2: 03-01-2004 MM DD YYYY | Date of Dose #3 (if Trumenba): 05-01-2004 MM DD YYYY |
| **Yellow Fever** | ☒ Yellow Fever<br>☐ Stamaril | Date of Dose: 06-01-2010 MM DD YYYY | | |
| **Typhoid** | Date of Dose: 06-01-2010 MM DD YYYY | | | |

## Part 4: Medical Provider Certification of the Above Information

| **Medical Provider Name** | **Medical Provider Signature** | **Date** |
|---|---|---|
| Dr Rubenstein | | 02-20-2024 Month Day Year |
| **Address** (Include city and state) 5 Pequot Pl. Westbrook, CT | | **Telephone** 203 555 1212 |
| **State or Country of Licensure / License #** CT 1234567 | | **Fax** 203 555 1213 |

Form must be stamped or Signed by Medical Provider

Stamp


Signature