

## 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	S, MUMPS, RUBEL	LA (MMR) IMM	UNITY – * ± Require	ed for all stud	lents		
Option 1	<ul> <li>Measles, Mumps, Rubella (MMR) Vaccination</li> <li>First dose must be given on or after your first birthday; second dose must be at least 28 days from first dose.</li> <li>If above not satisfied, obtain a booster and enter date given, or complete Option 2.</li> </ul>		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: Immune* 02-01-2024 MM DD YYYY					required to eive a booster and	
						por version and an experience of the second	
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 $-*\pm$ 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:  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	/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.	06 - 15 - 2023 MM DD YYYY  Date read: 06 - 30 - 2023  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 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:  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  Prizer  Novavax	
6. Hepatitis B Immunity – Documentation of a COM						
Hepatitis B Vaccine (enter name)  Date of Dose #1  O -O - 20  MM DD YYYY		22 03- <u>01</u>	applicable): -2022 05-61-2022		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: Gregg 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	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 203	555 1213		

Form must be stamped or Signed by Medical Provider

Stamp	3	Signature
<u>\$</u>	Dr Keith Davidson Provider No: 123456AB Heartland Medical Clinic 58 Norton Street St Ives Chase NSW 2075 Ph: 4366 3015 Fax: 4050 4064	