Yale HEALTH

Complete this form legibly and upload to:
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 • 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.	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. LAB RESULTS MUST BE ATTACHED	Measles Titer Result: ☒ Immune* 02-01-2024 MM DD YYYY Mumps Titer Result: ☒ Immune* 02-01-2024 MM DD YYYY 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. **Required:** ☐ Attach lab results	Varicella Titer Result: ☒ 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) Must cover strains A, C, Y, W-135 (Menactra, MenQUADfi Menveo, Nimenrix, or Penbraya)	Date: 01-01-2019 MM DD YYYY Vaccination MUST have been given WITHIN 5 years of your first day of class at Yale.	**Exceptions to requirement:** ☒ 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 Date: 01-01-2023 (MM DD YYYY) RESULT: ☒ NEG ☒ POS* **Required: ☒ Attach lab results.**	Date planted: 06-15-2023 (MM DD YYYY) Date read: 06-20-2023 (MM DD YYYY) Interpretation: ☒ NEG ☒ POS* mm of induration: 9	**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: 01-01-2024 (MM DD YYYY) ☒ Normal ☒ Abnormal	**TB TREATMENT** ☒ Latent TB Infection ☒ Active TB Infection Date(s): 06-30-2023 (MM DD YYYY) 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) ☒ Moderna ☒ Pfizer ☒ Johnson & Johnson/Janssen ☒ Novavax ☒ Other WHO approved Name: Bob	Date: 04-15-2021 (MM DD YYYY) ☒ Moderna ☒ Pfizer ☒ Novavax ☒ Other WHO approved Name: Sam	Date: 10-13-2023 (MM DD YYYY) ☒ Moderna ☒ Pfizer ☒ Novavax 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) 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: 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) Must be between September and March of CURRENT academic year

Student Name: Gregg Tester

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 ☒ 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 ☐ 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 ☐ 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

Kathleen Omollo