

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. MEASLE	S, MUMPS, RUBEL	LA (MMR) IMM	UNITY – * ± Require	ed for all stud	lents		
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: Immune* 02-01-2024 MM DD YYYY Rubella Titer Result: Immune* 02-01-2024 MM DD YYYY						
						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	ion 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 MM DD YYYY 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							
Must cover (Menactra,	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 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 ² 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 vaccin	e) COVID-1	9 updated 2023-2024 dose	
MM DD YYYY Moderna Pfizer Johnson & Johnson/Janssen Novavax		MM I Moderna Pfizer Novavax	MM DD YYYY Moderna Pfizer Novavax Other WHO approved		Date: LO - L3 - 2023 MM DD YYYY M Moderna Pfizer Novavax Name: Test	
6. Hepatitis B Immunity $-\pm$ 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)	Date of Dose #1: Date of Do Ol -Ol -2022 MM DD YYYY MM DE		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: Olivity Tdap is accepted within the past 10 years Olivity Tdap is accepted wit						
Influenza (Flu) Vaccination Date of Influenza Vaccination: \[\begin{align*} \text{\$\left(D - \begin{align*} \overline{13} - \overline{2013} \\ \text{MM DD YYYY} \\ \text{Must be between September and March of CURRENT academic year} \end{align*}						

Student Name: Grage Testary

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

OTHER VACCINES - NOT required				
Hepatitis A Vaccine	Date of Dose #1: (1 - 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: Date of Dose #2: Date of Dose #3: OL -OL - 2004 O3 -OL - 2004 O5 -OL - 2004 MM DD YYYY MM DD YYYY MM DD YYYY		
Meningococcal Serogroup B Vaccine	Bexsero, 2 doses Trumenba, 3 doses	Date of Dose #1: Date of Dose #2: Date of Dose #3 (if OL -OL - 2004 O3 - OL - 2004 Trumenba): 05 - OL - 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	Date 02_20_204 Month Day Year
Address (Include city and state) 5 Request Pl. West brook,		lephone 203 555 1212
State or Country of Licensure / License #	Fax 2	203555 1213

Form must be stamped or Signed by Medical Provider

Stamp	Signature
	DR. DIPALI GAIK WAD INTENSIVIST (SICU) INTENSIVIST