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 Testor4

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

GILLIAN RALLS, PA
YALE UNIVERSITY HEALTH SERVICES
STUDENT MEDICINE
55 LOCK STREET
P. O. BOX 208237
NEW HAVEN, CONNECTICUT 06520-8237
203-432-0319

Signature

Kathleen Omollo