Per the Connecticut State Department of Public Health it is MANDATORY that you complete the requirements and submit proof of immunizations before your arrival at Yale University.

Yale HEALTH

Incoming Undergraduate and Graduate Vaccination Record

2017-2018 Academic Year

Due: **May 31, 2017** for Fall Admission
January 2, 2018 for Spring Admission

See **pages 3 & 4 for instructions**

Last Name	**First Name**	**Date of Birth:** ____/____/____ Month Day Year
Home Address Street______ City/Town______ State______ Zip Code______ Country______		
E-mail	**Phone**	**Gender:** ☐ Male ☐ Female ☐ Transgender

REQUIRED VACCINATIONS or PROOF OF IMMUNITY:

Measles-Mumps-Rubella Vaccine	Date of Dose #1: ____ / ____ / ____ Month Day Year	Date of Dose #2: ____ / ____ / ____ Month Day Year	
OR Positive Titers for: Measles (Rubeola) Mumps Rubella	Titer Results: Measles: ________ Mumps: ________ Rubella: ________		PLEASE ATTACH ALL TITER RESULTS.
Varicella Vaccine	Date of Dose #1: ____ / ____ / ____ Month Day Year	Date of Dose #2: ____ / ____ / ____ Month Day Year	
OR Positive Titer for Varicella **OR** Physician Documented Disease (chicken pox).	Varicella Titer Results: ________	Date of Disease: ____ /____ /____ Month Day Year MD Signature: ________	PLEASE ATTACH ALL TITER RESULTS.
Meningococcal Vaccine - Quadrivalent Within the Past 5 Years (only if living in on campus dormitory facilities*)	Date of Last Dose: ____ / ____ / ____ Month Day Year	*Select Type*: Menactra ACWY Menveo Mencevax Nimenrix Menomune	
If the student has lived or traveled outside of the United States during the past year tuberculosis screening is REQUIRED			
Tuberculosis Skin Test (PPD) Within the Past 6 Months, **OR** Quantiferon Lab Test **OR** Chest Xray (if history of positive PPD)	Date of PPD Test: ____ / ____ / ____ Month Day Year Result: ________mm	Date of Quantiferon Test: ____ / ____ / ____ Month Day Year Result: ________ Date of Chest Xray: ____ / ____ / ____ Month Day Year Result: ________	PLEASE ATTACH QUANTIFERON LAB RESULT **OR** CHEST XRAY RESULT IF APPLICABLE

Clinician Name	**Clinician Signature**		**Date**
Address (Include city and state)	**Email**	**Telephone**	**Fax**

*On campus dormitory facilities include all the undergraduate residential colleges and the following graduate dormitories: 254 Prospect Street; 276 Prospect Street; Hall of Graduate Studies; Harkness Dormitory (Medical School) and Helen Hadley Hall.

LAST NAME: (PRINT)______________________________ FIRST NAME_________________________ DATE OF BIRTH ____/____/_____

RECOMMENDED VACCINES

Tetanus, Diptheria Pertussis	☐ Td ☐ Tdap *(preferred)* 1 dose within 10 years	____ / ____ / ____ Month Day Year		
Polio Vaccine	Date series completed or 1 dose IPV	____ / ____ / ____ Month Day Year		
Hepatitis B Vaccine	Series of 3 doses	Dose #1 ____ / ____ / ____ Month Day Year	Dose #2 ____ / ____ / ____ Month Day Year	Dose #3 ____ / ____ / ____ Month Day Year
Hepatitis A Vaccine	Series of 2 doses	Dose #1 ____ / ____ / ____ Month Day Year	Dose #2 ____ / ____ / ____ Month Day Year	
HPV Vaccine	Series of 3 doses	Dose #1 ____ / ____ / ____ Month Day Year	Dose #2 ____ / ____ / ____ Month Day Year	Dose #3 ____ / ____ / ____ Month Day Year
Meningococcal B **Vaccine**	☐ Bexsero, series of 2 ☐ Trumenba, series of 3	Dose #1 ____ / ____ / ____ Month Day Year	Dose #2 ____ / ____ / ____ Month Day Year	Dose #3 ____ / ____ / ____ Month Day Year

Options for submitting your completed forms and documentation:

Scan a high quality image and send it as a PDF file to: immunization@yale.edu

OR

Mail to:
Yale Health
New Student Forms
P.O. Box 208237
New Haven, CT 06520-8237
USA

OR

Courier to:
Yale Health
c/o Reginald MacDonald
HIM Department
55 Lock Street
New Haven, CT 06511
USA

Questions?
E-mail us at immunization@yale.edu

Clinician Name (MD, RN, PA)	**Clinician Signature**		**Date**
Address	**Email**	**Telephone**	**Fax**

Vaccination Record Instructions for all Incoming Undergraduate and Graduate Students per Connecticut Department of Public Health

Please be sure to check each date carefully before mailing or scanning as a PDF and emailing to immunization@yale.edu to eliminate delays in meeting these requirements.

Due Dates:
Spring Admission: January 2, 2017 *All Forms Must Be Completed in the English Language and signed by a Healthcare Provider*
Fall Admission: May 31, 2017 *All Forms Must Be Completed in the English Language and signed by a Healthcare Provider*

REQUIREMENTS

MMR (Measles, Mumps and Rubella):
Documentation must include either;

1. The dates of TWO MMR vaccinations GIVEN AFTER YOUR FIRST BIRTHDAY and GIVEN AT LEAST 28 DAYS APART.
   OR
2. (TITER) Blood test results that show that you have immunity to MMR/If any of these test results is negative, revaccination is required. (Send the actual lab report)

VARICELLA (Chickenpox):
Documentation must include either;

1. The dates of TWO VARICELLA vaccinations GIVEN AFTER YOUR FIRST BIRTHDAY and GIVEN AT
2. LEAST 28 DAYS APART.
   OR
3. (TITER) Blood test results that show that you have immunity to MMR/If any of these test results is negative, revaccination is required. (send the actual lab report)
   OR
4. The date of past infection (disease) and signed by a Nurse or Doctor

MENINGITS:
If you will be living in on campus housing, this vaccination must be given *within the past five years*. Be sure to circle the Vaccination given. The names of the acceptable vaccines are; Menactra, Menveo, Mencevax, Menomune or Nimenrix
Tuberculosis:
If you have lived or traveled outside of the United States, within the past six months, ask your doctor to complete TB Screening for you (please see the Yale Vaccination Record for further information)

RECOMMENDED

While Tdap, Polio, Hepatitis B, Hepatitis A, HPV Vaccine and Meningococcal B vaccination information may be submitted to complete your medical record, you are not required to provide this information.

STUDENTS REQUESTING MEDICAL OR RELIGIOUS WAIVERS

In the event that you are requesting a Medical Waiver from Vaccination, it will be necessary for you to;

1. Complete the Connecticut State Department of Public Health Medical Waiver Form, found at this url; http://www.ct.gov/dph/cwp/view.asp?a=3136&q=388416
2. Although written for minors, you may sign it as it applies to you
3. Have the document notarized by a Notary Public
4. Attach a letter from your physician explaining the reason for the medical waiver
5. In lieu of vaccinations, ask your physician to draw titers (blood tests to determine immunity) for measles, mumps, rubella and varicella and send the lab reports with the above-listed documentation.

In the event that you are requesting a Religious Waiver from Vaccination, it will be necessary for you to;

1. Complete the Connecticut State Department of Public Health Medical Waiver Form, found at this url; http://www.ct.gov/dph/cwp/view.asp?a=3136&q=388416
2. Although written for minors, you may sign it as it applies to you
3. Have the document notarized by a Notary Public
4. In lieu of vaccinations, ask your physician to draw titers (blood tests to determine immunity) for measles, mumps, rubella and varicella and send the lab reports with the above-listed documentation.

Sending Your Completed Forms (your options):

Scan your completed forms as a PDF and email them to us at immunization@yale.edu

OR

Mail them to us at:

Yale Health
New Student Forms
P.O. Box 208237
New Haven, CT 06520-8237

OR

Send them by courier (DHL, Fed Ex, etc.) to:

Yale Health
c/o Regina MacDonald
HIM Department
55 Lock Street
New Haven, CT 06511