

Yale HEALTH

Incoming Graduate & Professional Vaccination Record 2014-2015 Academic Year

See page 2 for submission instructions

Last Name		First Name		Date of Birth: ____/____/____ Month Day Year	
Home Address Street _____ City/Town _____ State _____ Zip Code _____ Country _____					
E-mail		Phone		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 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 ON CAMPUS*).	Date of Last Dose: ____/____/____ Month Day Year	<i>Select Type:</i> Menactra ACWY Menveo Mencevax Nimenrix Menomune	
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

*Campus housing includes 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.

It is MANDATORY that you complete the requirements and submit proof of immunizations before your arrival at Yale University.

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

RECOMMENDED VACCINES

Tetanus, Diphtheria Pertussis	1 dose within 10 years	____/____/____ Month Day Year	Select type: <input type="checkbox"/> Td <input type="checkbox"/> Tdap (<i>preferred</i>)		
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	

Mail your completed forms and documentation to:

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

Courier address:

Yale Health
 c/o Loretta Miller
 HIS 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