Yale HEALTH

55 Lock Street, New Haven, CT 06511

Yale University Student Health Requirements Information

READ ALL INFORMATION AND FOLLOW INSTRUCTIONS CAREFULLY TO AVOID ERRORS AND OMISSIONS

Dear Yale University Student,

On behalf of Yale University and Yale Health, we wish you the warmest welcome!

This packet outlines health requirements that must be completed prior to your established deadline for your program.

These requirements are mandated by Yale University policy and Connecticut State regulations**. If you do not complete health requirements before your established deadline, you may be blocked from registering for classes in the future.**

Key Points:

- **Forms:** Several forms require a signature from your healthcare provider.
- **Act Now: We strongly recommend that you schedule your appointment with your healthcare provider NOW**. Many providers are busy during the summer months and wait times may be long.
- **Deadlines:** You must complete health requirements by the established deadline for your program.

We know that you have much to complete prior to coming to campus, therefore we have provided a checklist and forms within this packet to help make sure this process is as straightforward as possible.

Yale Health at Yale University.

Revised: 02/12/2024

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Yale University Student Health Requirements Checklist

Documents within this packet:

FORM NAME	RECOMMENDED ACTION	❒ CHECKLIST ✓
Health Requirements Information	Read general welcome to the Health Requirements Information	❒ Reviewed this page
Vaccination and Titer (blood test) information	Read information about vaccinations and titers (blood tests)	❒ Reviewed this page
Health On Track Portal Information	Read general information about Yale's *Health On Track* Portal	❒ Reviewed this page
Student Health and Physical Exam Form	- Fill out the top demographic section with your information. - Take this form to your medical provider to be completed. - Submit this form to the *Health On Track* portal.	❒ Demographic section filled out. ❒ Healthcare provider completes form and signs it. ❒ Document uploaded to *Health On Track* portal.
Student Immunization and TB Testing History Form	- Fill out the top demographic section with your information. - Take this form to your medical provider to be completed. - Health Professionals Students must have TB Testing completed. - Submit this form to the *Health On Track* portal.	❒ Demographic section filled out. ❒ Healthcare provider completes form and signs it. ❒ Document uploaded to *Health On Track* portal.
Student Tuberculosis (TB) Risk Assessment Form (Not to be filled out by Health Professionals Students)	- Fill out the top demographic section with your information. - Take this form to your medical provider to be completed. - Submit this form to the *Health On Track* portal.	❒ Demographic section filled out. ❒ Healthcare provider completes form and signs it. ❒ Document uploaded to *Health On Track* portal.
Authorization for Medical Care and Treatment for Minors	**Only for Students under the age of 18 at the time of admission.** - Parent or Guardian must read and sign this document. - Submit this form to the Health On Track portal.	❒ Parent or Guardian signs document ❒ Document uploaded to *Health On Track* portal.

Important Dates for the Academic Year

Documentation	Fall Semester	Spring Semester	Summer Session
Received Admissions Packet with Health Requirements Information	Early April	September - November	January to May
Compile Health Requirements and Obtain Physical Exam	May – July	October – November	January to May
Log into Health On Track with Yale Net ID	End of July	End of November	Mid February
Activate your Yale MyChart with Activation Code received via mail	End of July	End of November	Late April *Not Applicable to Non-Degree Seeking Students
Submissions Deadline for Health Requirements	August 1	December 15	Session A – Mid April Session B – Mid May
Semester Begins	Late-August, 2024	Mid-January	Session A – Late May Session B – Late June
Get Required Influenza Vaccination	December 1st **	Must be completed prior to matriculation	*Not Applicable*

** Earlier date requirements may be in place for your specific cohort or program. Check with your school for details.

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Yale University Vaccination and Titer (blood test) Information

THE FOLLOWING ARE REQUIRED FOR ALL INCOMING STUDENTS

1. **Measles, Mumps, Rubella (MMR)**
    a. Option 1 – Vaccination
        i. Required to have two (2) doses. The first dose must be given on or after your first birthday, the second dose must be at least 28 days from the first dose.
        ii. If the above is not satisfied, please obtain a booster dose and enter that date.
    b. Option 2 – Titer (blood test)
        i. A titer showing immunity to each disease (Measles, Mumps and Rubella) is an acceptable alternative to vaccination. Lab records must be included as proof.

2. **Varicella (Chicken Pox) Immunity**
    a. Option 1 – Vaccination
        i. Required to have two (2) doses. The first dose must be given on or after your first birthday, the second dose must be at least 28 days from the first dose.
    b. Option 2 – Titer (blood test)
        i. A titer showing immunity to Varicella is an acceptable alternative to vaccination. Lab records must be included as proof.
    c. Option 3 – Certification of Past Disease
        i. Your medical provider can certify the date you had Varicella (Chickenpox) which would provide your immunity.

3. **Meningococcal Vaccination**
    a. Option 1 – Vaccination
        i. Vaccination required for all students living in university dormitories.
        ii. Vaccine must have been given WITHIN five (5) years of your first day of class.
        iii. Must cover strains A, C, Y, W-135)
    b. Option 2 – Exemption to requirement
        i. If you will not be living in university dormitories, you can elect to be exempt from this requirement by checking the applicable box.

4. **Tuberculosis (TB) Risk Assessment**
    a. All Non-Health Professionals Students are required to complete the Tuberculosis (TB) Risk Assessment Form.
    b. Students to complete the demographic information AND Part 1 of the form.

   i. If you answer YES to any of the screening questions, your medical provider must complete Part 2.
c. TB Testing is ONLY required for those who have a YES answer to any of the screening questions.

THE FOLLOWING ITEMS ARE REQUIRED ONLY FOR HEALTH PROFESSIONS STUDENTS

5. **Tuberculosis (TB) Screening**
   a. Screening consists of one of the following.
      i. TB Blood Test / IGRA (preferred)
         1. Must be within 6 months of matriculation date.
      ii. Skin testing / PPD
         1. Must be within 6 months of matriculation date.
   b. Positive screening tests must be followed up by Chest Xray and documentation of any treatment for TB.

6. **COVID-19 Vaccination (WHO approved)**
   a. Must be up-to-date with the most recent COVID vaccine
      i. Updated 2023-2024 mRNA vaccine (Pfizer or Moderna)
      ii. Updated 2023-24 protein subunit vaccine (Novavax)
   b. Please provide documentation of prior primary series doses of WHO approved COVID-19 vaccines in the space provided.

7. **Hepatitis B Immunity (must complete both)**
   a. Vaccination – Completed series (2 dose or 3 dose) Hepatitis B vaccination.
   b. Titer (blood test) – Quantitative Hepatitis B Surface Antibody titer
      i. Must have a numerical result indicating immunity.
      ii. Qualitative (tests that say Immune or Not immune only) are NOT ACCEPTED.
      iii. Titer can be performed at any time following vaccination; does not need to be recent as long as it indicates immunity.

8. **Tetanus – Diphtheria – Pertussis (Tdap) Vaccination**
   a. Vaccination within the past 10 years.

9. **Influenza Vaccination**
   a. Vaccination completed each academic year completed between September and March.
   b. Students in Online Physician Associate – Online Program MUST have this completed prior to matriculation.

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Yale University Health On Track Information

In the Spring of 2024, Yale University Campus Health Services along with the Yale Information Technology Team implemented a new Health Requirements Portal called: ***Health On Track***.

This system allows students to upload all of their required health information for processing, review and storage. This system was created to provide a single place for students to address any health requirements they may have based on their health status and educational affiliation.

Once you receive your NetID from Yale you will have access to the *Health On Track* portal to begin uploading the information from this packet. **The *Health On Track* portal will open for students by mid-May, 2024. Please watch for a communication from your school once the portal is open.**

Please double check all forms prior to uploading them to the portal to avoid unnecessary delays in processing. Any forms filled out by your medical provider need to be signed by the provider or they are not valid.

All documentation must be provided in English (or translated to English) prior to submitting for review.

In addition, vaccine, or titer (blood test) information must be entered onto the forms. Attached vaccination records and/or lab test results will result in delays and errors in completing health requirements.

If you have concerns or questions about a specific requirement, you can contact the Campus Health team via the portal. If you are experiencing technical issues with the portal, please email campus.health.systems@yale.edu. If you have other issues, questions or concerns please email campushealthcompliance@yale.edu.

Yale Health at Yale University.

Revised: 02/12/2024

Yale HEALTH

Complete this form legibly and upload to:
https://healthontrack.yale.edu

Yale University Student Health and Physical Exam Form

Last Name	First Name	Date of Birth: ____ -___ -_____ MM DD YYYY	Chosen Name	
E-mail	**Phone**	**Sex Assigned at Birth**	**Gender Identity**	**Pronouns**

Department/Program of Study at Yale (Check one)
❒Undergraduate ❒Graduate ❒Summer ❒School of Medicine ❒School of Nursing ❒Physician Associate Program

Home Address	City/State	ZIP	Parent/Guardian Home Phone	Parent/Guardian Work Phone

Emergency Contact Name	Emergency Contact Relationship	Emergency Contact Phone

Health History | To be completed by Medical Provider

Vital Signs	**Height** _____ inches	**Weight** _____ lbs	**Blood Pressure:** _____/_____ Systolic / Diastolic	**Pulse:** _____ bpm	
Allergies	Allergies to medications? ❒ NO ❒ YES – please list:_____ _____ Severe Food Allergy? ❒ NO ❒ YES – please list:_____ _____				
If this patient receives allergy immunotherapy, please complete the Student Allergy Medical Treatment Plan form.					
Current Medications	Please list: _____ _____ _____				
Vitamins Supplements Over The Counter(s)	Please list: _____ _____ _____				
Current or past medical, surgical, or psychiatric condition(s)	Please list: _____ _____ _____ _____ _____				

Clinical Evaluation	Normal	Abnormal	Comments
Skin			
Head, ears, eyes, nose, throat,			
Mouth			
Neck and thyroid			
Lungs/Chest			
Heart			
Abdomen			
Back/Spine			
Extremities/Musculoskeletal			
Neurologic			
Emotional/Psychological			
Other findings			

Part 4: Medical Provider Certification of the Above Information

I have reviewed the medical history and examined the student noted above; the information is accurate and complete to the best of my knowledge. The student is cleared medically and psychologically to participate in the demands of college life.

❒ Yes/Unlimited activity and fit for college

❒ No/Limited activity

Reason: _____

Recommendations: _____

_____

Medical Provider Name	**Medical Provider Signature**	**Date**
Address (Include city and state)		**Telephone**
State or Country of Licensure / License #		**Fax**

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	
E-mail	**Phone**	**Sex Assigned at Birth**	**Gender Identity**	**Pronouns**

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

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: ___ -___ -_____ MM DD YYYY	Dose #2: ___ -___ -_____ MM DD YYYY	Booster (if indicated): ___ -___ -_____ 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* ___ -___ -_____ MM DD YYYY Mumps Titer Result: ❒ Immune* ___ -___ -_____ MM DD YYYY Rubella Titer Result: ❒ Immune* ___ -___ -____ 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

Option 1	Varicella Vaccination – first dose must be given on or after your first birthday to be accepted.	Dose #1 ___ -___ -_____ MM DD YYYY	Dose #2: ___ -___ -_____ 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* ___ -___ -_____ 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: ___ -___ -_____ 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: ___ -___ -_____ 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.

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: ___ -___ -_____ MM DD YYYY RESULT: ❒ NEG ❒ POS* **Required: ❒ Attach lab results.**	Date planted: ___ -___ -_____ MM DD YYYY Date read: ___ -___ -_____ MM DD YYYY Interpretation: ❒ NEG ❒POS* mm of induration: _____	**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: ___ -___ -_____ MM DD YYYY ❒ Normal ❒Abnormal	**TB TREATMENT** ❒ Latent TB Infection ❒ Active TB Infection Date(s): ___ -___ -_____ MM DD YYYY List Medication(s):

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: ___ -___ -_____ MM DD YYYY ❒ Moderna ❒ Pfizer ❒ Johnson & Johnson/Janssen ❒ Novavax ❒ Other WHO approved Name:	Date: ___ -___ -_____ MM DD YYYY ❒ Moderna ❒ Pfizer ❒ Novavax ❒ Other WHO approved Name:	Date: ___ -___ -_____ MM DD YYYY ❒ Moderna ❒ Pfizer ❒ Novavax Name:

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)
	___ -___ -_____ MM DD YYYY	___ -___ -_____ MM DD YYYY	___ -___ -_____ MM DD YYYY	___ -___ -_____ MM DD YYYY Result: _____ 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: ___ -___ -_____ 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: ___ -___ -_____ MM DD YYYY Must be between September and March of CURRENT academic year

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

OTHER VACCINES - NOT required				
Hepatitis A Vaccine	Date of Dose #1: ___ -___ -_____ MM DD YYYY	Date of Dose #2: ___ -___ -_____ MM DD YYYY		
HPV Vaccine	❒ HPV 4 ❒ HPV 9	Date of Dose #1: ___ -___ -_____ MM DD YYYY	Date of Dose #2: ___ -___ -_____ MM DD YYYY	Date of Dose #3: ___ -___ -_____ MM DD YYYY
Meningococcal Serogroup B Vaccine	❒ Bexsero, 2 doses ❒ Trumenba, 3 doses	Date of Dose #1: ___ -___ -_____ MM DD YYYY	Date of Dose #2: ___ -___ -_____ MM DD YYYY	Date of Dose #3 (if Trumenba): ___ -___ -_____ MM DD YYYY
Yellow Fever	❒ Yellow Fever ❒ Stamaril	Date of Dose: ___ -___ -_____ MM DD YYYY		
Typhoid	Date of Dose: ___ -___ -_____ MM DD YYYY			

Part 4: Medical Provider Certification of the Above Information

Medical Provider Name	**Medical Provider Signature**	**Date** ___ -___ -_____ Month Day Year
Address (Include city and state)		**Telephone**
State or Country of Licensure / License #		**Fax**

Yale HEALTH

Complete this form legibly and upload to:
https://healthontrack.yale.edu

Yale University Student Tuberculosis (TB) Risk Assessment and Testing Form

THIS FORM IS REQUIRED AND WILL BE READ ELECTRONICALLY. DATES MUST BE ENTERED ON THIS FORM.
All dates must in MM-DD-YYYY format.

Last Name	First Name	Date of Birth: ____ -____ -_____ MM DD YYYY	Chosen Name	
E-mail	**Phone**	**Sex Assigned at Birth**	**Gender Identity**	**Pronouns**

Department/Program of Study at Yale (Check one)
❒Undergraduate ❒Graduate ❒Summer

HEALTH PROFESSIONS STUDENTS DO NOT COMPLETE THIS FORM – TB TESTING IS REQUIRED FOR YOUR PROGRAMS AND IS DOCUMENTED ON THE IMMUNIZATIONS AND TB TESTING FORM

Part 1: Students complete this section – If you answer YES to any question your medical provider must complete Part 2.

TUBERCULOSIS RISK ASSESSMENT

Section A: History of TB

1. Have you ever been sick with (had symptoms and diagnosed) TB? ❒ Yes ❒ No
2. Have you ever had a positive TB Test (PPD, QuantiFERON test or T-Spot)? ❒ Yes ❒ No

Section B: Risk Assessment for TB

1. Were you born in, or have you lived, worked, or visited for more than one (1) month any country not including the following: United States, Canada, Australia, New Zealand, Northern or Western European country? ❒ Yes ❒ No
2. Do you have current or planned immunosuppression due to: HIV Infection, organ transplant recipient, treatment with a TNF-blocker (e.g. infliximab, etanercept, or others), chronic steroids, other immunosuppressive medications? ❒ Yes ❒ No
3. Do any of the following conditions or situations apply to you?
   a. Do you have a persistent cough (three (3) weeks or more), fever, night sweats fatigue, loss of appetite or unexplained weight loss? ❒ Yes ❒ No
   b. Have you ever lived with or been in close contact with a person known or suspected of being sick with TB? ❒ Yes ❒ No
   c. Have you ever lived, worked, or volunteered in any homeless shelter, prison/jail, hospital or drug rehabilitation unit, nursing home, or residential healthcare facility? ❒ Yes ❒ No

Student Signature: _____ **Date:** _____

If you answered no to all the above questions, skip Part 2; you are finished with this form.
If you answered YES to any of the above questions, your healthcare provider must complete Part 2 on the next page.

Part 2: TB Testing to be completed by Medical Provider

ATTENTION HEALTHCARE PROVIDER: If the patient answered **YES** to any above questions, proof of a QuantiFERON Gold / T-Spot (preferred) OR PPD skin test is **REQUIRED**. If QuantiFERON Gold / T-Spot results are positive OR PPD results are 10mm or more, a Chest X-ray is **REQUIRED**. Testing must be done within six (6) months prior to admittance (unless history of positive TB testing). If there is a history of positive TB testing, a chest x-ray is required. History of BCG vaccination does not prevent testing of someone in a high-risk group.

Documentation of any Treatment for Latent or Active TB must also be recorded below.

<table>
<tr><th colspan="4">TUBERCULOSIS (TB) Testing – Required for Students with Positive Risk Assessment Screen</th></tr>
<tr><th colspan="2">STEP 1: TB Blood Test/IGRA OR TB Skin Test (PPD)</th><th colspan="2">STEP 2: *DO NOT COMPLETE UNLESS POSITIVE TB SKIN TEST OR TB BLOOD TEST</th></tr>
<tr>
<td>❒ QuantiFERON ❒ T-Spot

Date: ____ -____ -_____
MM DD YYYY

RESULT: ❒ NEG ❒ POS*

Required: ❒ Attach lab results.</td>
<td>Date planted:
____ -____ -_____
MM DD YYYY
Date read:
____ -____ -_____
MM DD YYYY
Interpretation: ❒NEG
❒POS*

mm of induration: _____</td>
<td>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:
____ -____ -_____
MM DD YYYY

❒ Normal ❒ Abnormal</td>
<td>TB TREATMENT
❒ Latent TB Infection
❒ Active TB Infection

Date(s): ____ -____ -_____
MM DD YYYY
List Medication(s):</td>
</tr>
<tr>
<td>If positive TB test but no treatment was completed, please document why:</td>
<td colspan="3">❒ Patient counseled about risk/benefit of treatment of LTBI but ultimately refused.

❒ Other (specify):</td>
</tr>
</table>

Medical Provider Name	**Medical Provider Signature**	**Date**
Address (Include city and state)		**Telephone**
State or Country of Licensure / License #		**Fax**

Yale HEALTH

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Yale University Authorization for Medical Care and Treatment for Minors

THIS FORM IS REQUIRED FOR ALL STUDENTS UNDER 18 YEARS OF AGE.

Last Name	**First Name**	**Date of Birth:** ___ -___ -____ MM DD YYYY		**Chosen Name**
E-mail	**Phone**	**Sex Assigned at Birth**	**Gender Identity**	**Pronouns**
Department/Program of Study at Yale (Check one) ❒Undergraduate ❒Graduate ❒Summer ❒School of Medicine ❒School of Nursing ❒Physician Associate Program				

Yale Health Center requests that at the time of admission, the parents, or legal guardians of students under the age of 18 provide written authorization for Yale Health Center to provide medical care and treatment, including mental health and counseling services, to minor students.

The undersigned hereby grants permission for medical care and treatment, including mental health and counseling, to be provided by Yale Health Center staff to:

_____ _____

Printed Name of Parent/Guardian | Relationship to Student

_____ _____

Signature of Parent/Guardian | Date