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 or office stamp 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.

Yale HEALTH

55 Lock Street, New Haven, CT 06511

Yale University Student Health Requirements Checklist

Documents within this packet:

FORM NAME	ACTION TO TAKE	❒ CHECKLIST ✓
Health Requirements Information (page 1)	Read general welcome to the Health Requirements Information	❒ Reviewed this page
Vaccination and Titer (blood test) information (pages 4 & 5)	Read information about vaccinations and titers (blood tests)	❒ Reviewed this page
Health Portal Information (page 6)	Read general information about Yale's *Health* Portal	❒ Reviewed this page
Student Health and Physical Form (pages 7 & 8)	- Fill out the top demographic section with your information. - Take this form to your medical provider to be completed. - Email completed form to yhmedicalrecords@yale.edu.	❒ Demographic section filled out. ❒ Healthcare provider completes form and signs/stamps it. ❒ Document sent to Yale Health.
Student Immunization Form (pages 9 - 11)	- 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 portal.*	❒ Demographic section filled out. ❒ Healthcare provider completes form and signs/stamps it. ❒ Document uploaded to *Health* portal.
Student Tuberculosis (TB) Risk Assessment Form (Not to be filled out by Health Professionals Students) (pages 12 & 13)	- 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 portal.*	❒ Demographic section filled out. ❒ Healthcare provider completes form and signs/stamps it. ❒ Document uploaded to *Health* portal.
Authorization for Medical Care and Treatment for Minors (page 14)	**Only for Students under the age of 18 at the time of admission.** - Parent or Guardian must read and sign this document. - Send completed form to. yhmedicalrecords@yale.edu.	❒ Parent or Guardian signs document ❒ Document sent to Yale Health.

Important Dates for the Academic Year

Documentation	Fall Semester	Spring Semester	Summer Session
Received Admissions Packet with Health Requirements Information	April - May	September - November	January to May
Compile Health Requirements and Obtain Physical Exam	May – July	October – November	January to May
Log into Health portal with Yale Net ID	End of June - July	End of November	Mid February
Activate your Yale MyChart with Activation Code received via mail	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 (program dependent)	Late-August	Mid-January	Session A – Late May Session B – Late June
Get Required Influenza Vaccination (Health Professions Students)	December 1st	Must be completed prior to matriculation	*Not Applicable*

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

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 program start date AND after your 16th birthday.
        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 program start date.
      ii. Skin testing / PPD
         1. Must be within 6 months of program start 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 dose of COVID vaccine (Pfizer, Moderna or Novavax)
   b. Please provide documentation of prior primary series doses of WHO approved COVID-19 vaccines.

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 test results that **ONLY** say “Immune” or “Not immune” 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.

Yale University Health Portal Information

Yale Health uses Medicat* as their current health portal. You can access this portal via https://yale.medicatconnect.com (you will need your NET ID, emailed to you separately). This system allows students to upload all of their required health information for processing, review and storage.

The most efficient way to meet your health requirements is to make sure that your forms are completed fully and legibly. Pay close attention to the following:

- Any forms filled out by your medical provider need to be signed or stamped or they are not valid.
- All dates and tests should be filled in on the forms. If your provider does not fill in the dates but provides you with other records, you may enter the dates yourself using your documentation.
- Please use your legal name as submitted when applying to Yale on the forms so we match your records.
- All dates must be in a MM – DD – YYYY format (Month – Day – Year).
- Lab results for immunity (titers) must be included with the submitted form.
- All documentation must be provided in English (or translated to English) prior to submitting for review.

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.

Yale HEALTH

Email to yhmedicalrecords@yale.edu (preferred)
Mail: P.O. Box 208237, New Haven, CT 06520 Fax: 203-436-5536

Student Health and Physical Form

THIS FORM IS REQUIRED AND WILL BE READ ELECTRONICALLY.

LEGAL Last Name	LEGAL First Name	Date of Birth	NETID
		____ - ___ - _____ MM DD YYYY	

Chosen Name	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/Country	ZIP Code	Parent/Guardian Phone

Emergency Contact Name	Emergency Contact Relationship	Emergency Contact Phone

Health History | To be completed by Medical Provider

	Height	Weight	Blood Pressure:	Pulse:	BMI:
Vital Signs	_____ in OR _____ cm	_____ lbs OR _____ kg	_____/_____ Systolic / Diastolic	_____ bpm	_____ kg/m2

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** ___ -___ -_____ MM DD YYYY
Address (Include city and state)		**Telephone**
State or Country of Licensure / License #		**Fax**

Provider Office Stamp

Yale HEALTH

Complete this form legibly and upload to:
Yale Health Portal

Student Immunization Form

THIS FORM IS REQUIRED AND WILL BE READ ELECTRONICALLY.

All dates must in MM-DD-YYYY format

LEGAL Last Name	LEGAL First Name		Date of Birth ___ -___ -_____ MM DD YYYY	NETID
Chosen Name	**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. **Required**: ❒ Attach lab results	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 program start date 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

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)
Required: ❒ Attach lab results.	___ -___ -_____ 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	Influenza vaccination documentation must be submitted onto your ***Health On Track*** portal during the season each year between September and December.

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** ___ -___ -_____ MM DD YYYY
Address (Include city and state)		**Telephone**
State or Country of Licensure / License #		**Fax**
	Provider Office Stamp	

Yale HEALTH

Complete this form legibly and upload to:
Yale Health Portal

Student Tuberculosis (TB) Risk Assessment and Testing Form

THIS FORM IS REQUIRED AND WILL BE READ ELECTRONICALLY

All dates must in MM - DD -YYYY format

LEGAL Last Name	LEGAL First Name	Date of Birth ____ - ____ - ____ MM DD YYYY	NETID

Chosen Name	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: <u>Students complete this section</u> – 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** ___ -___ -_____ MM DD YYYY
Address (Include city and state)		**Telephone**
State or Country of Licensure / License #		**Fax**

Provider Office Stamp

Yale HEALTH

Email to yhmedicalrecords@yale.edu (preferred)
Mail: P.O. Box 208237, New Haven, CT 06520 Fax: 203-436-5536

Authorization for Medical Care and Treatment for Minors

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

LEGAL Last Name	**LEGAL First Name**	**Date of Birth** ___ - ___ - _____ MM DD YYYY	**NETID**

Chosen Name	**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