Yale HEALTH

Incoming Undergraduate 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:** ☐ 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 ON CAMPUS*).	Date of Last Dose: ____ / ____ / ____ Month Day Year	*Select Type*: 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, Diptheria Pertussis	1 dose within 10 years	____ / ____ / ____ Month Day Year	Select type: ☐ Td ☐ Tdap *(preferred)*		
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**