

Submit all completed forms and attachments by scanning and uploading them to the vaccine portal <https://yale.medicatconnect.com>. Session A Deadline: April 24, 2023. Session B Deadline: May 29, 2023

Last Name	First Name	Date of Birth: <small>Month Day Year</small> ____/____/____	Preferred Name
E-mail	Phone	Sex Assigned at Birth	Gender Identity
Department/Program of Study at Yale			

## IMMUNIZATION HISTORY

### 1. MEASLES, MUMPS, RUBELLA (MMR)Vaccination – required for all students

<b>Option 1</b>	Measles, Mumps, Rubella (MMR) Vaccination <ul style="list-style-type: none"> <li>First dose must be given on or after your first birthday; second dose must be at least 28 days beyond first dose.</li> <li>If above not satisfied, obtain a booster and enter date given, or complete Option 2 below.</li> </ul>	Dose #1: ____/____/____ <small>Month Day Year</small>	Dose #2: ____/____/____ <small>Month Day Year</small>	Booster (if indicated): ____/____/____ <small>Month Day Year</small>
<b>Option 2</b>	In lieu of proof of vaccination above, a titer showing immunity to each individual disease is an acceptable alternative to vaccination. <b>Required:</b> <input type="checkbox"/> Attach lab results	Measles Titer Result: <input type="checkbox"/> Immune* Date _____ (month/day/year) Mumps Titer Result: <input type="checkbox"/> Immune* Date _____ (month/day/year) Rubella Titer Result: <input type="checkbox"/> Immune* Date _____ (month/day/year) *If not immune, you are required to receive a booster and repeat the titer.		

### 2. VARICELLA Vaccination – required for all students born after 1979

<b>Option 1</b>	Varicella Vaccination – first dose must be given on or after your first birthday to be accepted	Dose #1: ____/____/____ <small>Month Day Year</small>	Dose #2: ____/____/____ <small>Month Day Year</small>
<b>Option 2</b>	In lieu of proof of vaccination above, a titer showing immunity is an acceptable alternative to vaccination. <b>Required:</b> <input type="checkbox"/> Attach lab results	Varicella Titer Result: <input type="checkbox"/> Immune* Date _____ (month/day/year) *If not immune, you are required to receive a booster and repeat the titer	
<b>Option 3</b>	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: ____/____/____ <small>Month Day Year</small>	

### 3. MENINGOCOCCAL Vaccination – required of all undergraduate and graduate students living in university dormitories

Meningitis Vaccine (MCV 4)	Date: ____/____/____ <small>Month Day Year</small>	<b>Exceptions to requirement:</b>
Must cover strains A, C, Y, W-135 (Menactra, Menveo or Nimenrix)	Vaccination MUST have been given WITHIN 5 years of your first day of class at Yale and remain up to date throughout your time at Yale.	<input type="checkbox"/> I will not be living in university-owned dormitories. <input type="checkbox"/> I am over 29 years of age.

### 4. TUBERCULOSIS (TB) –

**ONLY** If the student has lived or traveled outside the United States during the past year tuberculosis (TB) screening is **REQUIRED**

<b>STEP 1: TB Blood Test/IGRA</b>	OR	<b>TB Skin Test (PPD)</b>	<b>STEP 2: DO NOT COMPLETE UNLESS POSITIVE TB SKIN TEST OR TB BLOOD TEST</b>
<b>Recommended if prior BCG</b> <input type="checkbox"/> Quantiferon <input type="checkbox"/> T-Spot Date: ____/____/____ <small>Month Day Year</small> RESULT: <input type="checkbox"/> NEG <input type="checkbox"/> POS* <b>Required:</b> <input type="checkbox"/> Attach lab results.		Date planted: ____/____/____ <small>Month Day Year</small> Date read: ____/____/____ <small>Month Day Year</small> Interpretation: <input type="checkbox"/> NEG <input type="checkbox"/> POS* mm of duration: ____	Required <b>ONLY</b> if past or current positive TB skin or blood test. Not required if completed medication treatment for TB. Chest X-ray Date: ____/____/____ <small>Month Day Year</small> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Latent TB Infection <input type="checkbox"/> Active TB Infection Date(s): _____ List Medication(s): _____

\*ONLY If test is POSITIVE, proceed TO Step 2 →

**7. COVID-19 VACCINATION – REQUIRED for all students**

- Must have completed FDA or WHO-approved primary series. See [WHO approved vaccines](#) AND
- Must have updated bivalent booster (available only after Sept 1, 2022 in the US)

PRIMARY DOSE #1	PRIMARY DOSE #2 (skip if J&J vaccine)	UPDATED BIVALENT BOOSTER
Date ___/___/___ Month Day Year <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> Johnson&Johnson/Janssen <input type="checkbox"/> Novavax <input type="checkbox"/> Other WHO approved Name:	Date ___/___/___ Month Day Year <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> Novavax <input type="checkbox"/> Other WHO approved Name:	Date ___/___/___ Month Day Year <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer

OTHER VACCINES - NOT required				
Tetanus-Diphtheria-Pertussis within the past 10 years	Date of most recent dose: ___/___/___ Month Day Year	Only Tdap is accepted		
Hepatitis A Vaccine	Date of Dose #1: ___/___/___ Month Day Year	Date of Dose #2: ___/___/___ Month Day Year		
Hepatitis B Vaccine (enter name)	Date of Dose #1: ___/___/___ Month Day Year	Date of Dose #2: ___/___/___ Month Day Year	Date of Dose #3 (if applicable): ___/___/___ Month Day Year	Hep B Surface Antibody Titer ___/___/___ Month Day Year Result: <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
HPV Vaccine	<input type="checkbox"/> HPV 4 <input type="checkbox"/> HPV 9	Date of Dose #1: ___/___/___ Month Day Year	Date of Dose #2: ___/___/___ Month Day Year	Date of Dose #3: ___/___/___ Month Day Year
Meningococcal Serogroup B Vaccine	<input type="checkbox"/> Bexsero, 2 doses <input type="checkbox"/> Trumenba, 3 doses	Date of Dose #1: ___/___/___ Month Day Year	Date of Dose #2: ___/___/___ Month Day Year	Date of Dose #3 (if Trumenba): ___/___/___ Month Day Year
Yellow Fever	<input type="checkbox"/> Yellow Fever <input type="checkbox"/> Stamaril	Date of Dose: ___/___/___ Month Day Year		
Typhoid	Date of Dose: ___/___/___ Month Day Year			
Patient Name		Patient Date of Birth		
Clinician Name	Clinician Signature		Date	
Address (Include city and state)	Email	Telephone	Fax	

**Vaccine Portal Guide**

The vaccine portal (<https://yale.medicatconnect.com>) is open for incoming Yale Summer Session students. You will need your NetID and password in order to access the portal. Deadline for submission is April 24, 2023 for Session A and May 29 for Session B; however, please submit as soon as you are able. In the event you do not have all of the necessary vaccinations and/or titers, completion of next steps can take up to several weeks. Note that if all information is not in and verified by Medicat, you WILL NOT be able to register for classes.

1. Bring this form to your primary care provider for completion. Verify that all necessary information is indicated and correct. You might be due for a booster or titers.
2. Go to the vaccine portal. ENTER ALL DATES for the various vaccines or titers AND upload this immunization form and attachments.
3. Verification of immunizations can take up to 7 days.
4. Read all email notifications from Medicat. These are alerting you to missing or incorrect information. Follow provided instructions. As long as you are receiving alerts, you ARE NOT cleared to register for classes. If instructions are unclear, email [complianceservices@medicat.com](mailto:complianceservices@medicat.com) for clarification. If after discussion with Medicat, you remain unclear as to next steps, email Yale Health at [immunization@yale.edu](mailto:immunization@yale.edu). Please do not email both at once. High volume into [immunization@yale.edu](mailto:immunization@yale.edu) will lead to delays in assistance.
5. If you are coming from outside the US, and cannot obtain any of the required vaccinations prior to arrival here on campus, please notify Yale Health at [immunization@yale.edu](mailto:immunization@yale.edu) so that we can formulate a plan.
6. **Off health hold** status indicates that you have satisfied all immunization requirements.