Yale UNIVERSITY HEALTH SERVICES

Health Professions Vaccination Record

2009-2010 Academic Year

(check one) ☐ **School of Medicine** ☐ **School of Nursing** ☐ **Physician's Associate Program**

Due: **July 20, 2009**

Return To:
Yale University Health Services
New Student Forms
17 Hillhouse Ave.
P.O. Box 208237
New Haven, CT 06520-8237
USA

Last Name	**First Name**	**Date of Birth:** ____/____/____ Month Day Year
E-mail	**Phone**	**Gender:** ☐ Male ☐ Female ☐ Transgender

Questions? Visit our Frequently Asked Questions (FAQ's): **www.yale.edu/yhp/med_services/immunization** or e-mail us **immunization@yale.edu**.

REQUIRED

Vaccine	Requirement				
Measles, Mumps, Rubella **MMR - combined**	2 doses or a positive titer. Dose #1 on or after first birthday. Dose #2 at least 30 days after 1st dose and after 1/1/80.	Dose #1 ____ / ____ / ____ Month Day Year	Dose #2 ____ / ____ / ____ Month Day Year	☐ Attach titers	
OR					
If single vaccines	2 doses of **measles vaccine** or a positive titer	Dose #1 ____ / ____ / ____ Month Day Year	Dose #2 ____ / ____ / ____ Month Day Year	☐ Attach titer	
	2 doses of **mumps vaccine** or a positive titer	Dose #1 ____ / ____ / ____ Month Day Year	Dose #2 ____ / ____ / ____ Month Day Year	☐ Attach titer	
	1 dose of **rubella vaccine** or a positive titer	____ / ____ / ____ Month Day Year	☐ Attach titer		
Meningococcal Vaccine (on or after 1/1/05) ***if living on campus**	Select type: ☐ Menomune® ☐ Menactra® ☐ Mencevax® ☐ ACWY vax®	____ / ____ / ____ Month Day Year	☐ Not living on campus		
Varicella Vaccine	2 doses, disease date or positive titer	Dose #1 ____ / ____ / ____ Month Day Year	Dose #2 ____ / ____ / ____ Month Day Year	Disease Date ____ / ____ / ____ Month Day Year	☐ Attach titer
Tetanus, Diptheria Pertussis	One dose within 10 years Select type: ☐ Td ☐ Tdap *(preferred)*	____ / ____ / ____ Month Day Year			
Polio Vaccine	Date series completed or 1 does IPV	____ / ____ / ____ Month Day Year			
Hepatitis B Quantitative Titer	Quantitative titer	☐ Attach titer			
Hepatitis B Vaccine	Series of 3 doses	Dose #1 ____ / ____ / ____ Month Day Year	Dose #2 ____ / ____ / ____ Month Day Year	Dose #3 ____ / ____ / ____ Month Day Year	
PPD Tuberculin skin test (Mantoux)	After January 2009	Date given ____ / ____ / ____ Month Day Year	Date read ____ / ____ / ____ Month Day Year	Result: _____ mm induration ☐ Positive ☐ Negative If PPD is positive attach: ☐ Chest x-ray report and ☐ Treatment report	

RECOMMENDED

Vaccine	Requirement			
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

Clinician Signature	**Telephone**	**Date**
Address	**Fax**	

* Campus housing includes the residential colleges and the following graduate dormitories:

- 254 Prospect Street
- 276 Prospect Street
- Hall of Graduate Studies
- Harkness Dormitory (Medical School)
- Helen Hadley Hall