Dear Incoming Student,

Welcome to Yale University! In advance of your arrival, the following information is designed to assist you and your healthcare provider in understanding of the Connecticut State Department of Public Health’s Immunization Requirements.

Please read this information carefully and please provide this information to your healthcare provider. This will save you both time and expense.

Follow these instructions:

1. Print the vaccination record form and these instructions now.
2. Take them to your healthcare provider (physician, nurse practitioner, physician assistant, etc.) and have them fully complete the form.
3. On or after June 20, 2018, go to https://yale.medicalconnect.com.
   a. Enter your Yale NetID and password to log in.
   b. Enter the dates of all vaccinations.
   c. Scan or take a photo and upload this vaccination form and all supporting documents.
   d. Upload all of your forms and all of your documentation for verification purposes (scanned or photo)
   e. Await review and verification (1-5 business days)
   f. Respond, if necessary, to requests for further information or requests for corrective action.

The process of receiving these vaccinations, titer, etc. and meeting these requirements may take several months to complete, so please make an appointment with your healthcare provider as quickly as possible.

PLEASE BEGIN THIS PROCESS NOW.

Essential Information for all Incoming Undergraduate and Graduate Students & Their Healthcare Providers

REQUIRED VACCINATIONS/TITERS

MMR (Measles, Mumps & Rubella)

- Two measles, mumps and rubella vaccinations administered AFTER your FIRST BIRTHDAY and administered at least 28 DAYS APART.
  OR
- TITER - Blood test results that show that you have immunity to MMR. If any of these tests are negative, revaccination is required. Upload the lab report with your completed vaccination record.

Varicella (chickenpox)

- Two varicella vaccinations administered AFTER your FIRST BIRTHDAY and administered at least 28 DAYS APART.
  OR
- Documentation of date of disease as witnessed/treated by your healthcare provider.
  OR
- TITER - Blood test results that show that you have immunity to varicella. If this test is negative, revaccination is required. Upload the lab report with your completed vaccination record.
Meningitis

- If you will be living in on-campus housing (dormitory facility), you are required to document the administration of one quadrivalent meningitis vaccination administered within the past five years. The only vaccines accepted are: ACWY, Menevo, Nimenrix, Menactra, Mencevax, Menomune.

- On campus dormitory facilities include all the undergraduate residential colleges and the following graduate dormitories: 254 Prospect Street, 272 Elm Street, 276 Prospect Street, Baker Hall, Harkness Dormitory (Medical School), and Helen Hadley Hall.

Tuberculosis (TB) Screening

- If you have lived or traveled outside of the U.S. within the past year, ask your healthcare provider to complete a TB Screen Testing and document it on the immunization record.
- Chest Xray reports and QuantiFERON lab reports must be uploaded with your completed vaccination record.

RECOMMENDED VACCINATIONS

While Tdap, hepatitis B, hepatitis A, HPV vaccine and meningitis B vaccination information may be submitted to complete your medical record, you are not required to provide this information.

REQUESTING MEDICAL OR RELIGIOUS WAIVERS

Medical Waiver from Vaccination

In the event that you are requesting a Medical Waiver from Vaccination you must:

2. Although written for minors, you may sign it as it applies to you.
3. Have the document notarized by a Notary Public.
4. Attach a letter from your physician explaining the reason for the medical waiver.
5. In lieu of vaccinations, ask your physician to draw titers (blood tests to determine immunity) for measles, mumps, rubella and varicella and send the lab reports with the above-listed documentation.

Religious Waiver from Vaccination

In the event that you are requesting a Religious Waiver from Vaccination, you must:

2. Although written for minors, you may sign it as it applies to you.
3. Have the document notarized by a Notary Public.
4. In lieu of vaccinations, ask your physician to draw titers (blood tests to determine immunity) for measles, mumps, rubella and varicella and send the lab reports with the above-listed documentation.
Undergraduate and Graduate Student Vaccination Record

1. Print this form and the instructions now.
2. Take them to your healthcare provider (physician, nurse practitioner, physician assistant, etc.) and have them fully complete the form.
3. On or after June 20, 2018, go to https://yale.medicalconnect.com.
   a. Enter your Yale NetID and password to log in.
   b. Enter the dates of all vaccinations.
   c. Scan or take a photo and upload this vaccination form and all supporting documents.
   d. Upload all of your forms and all of your documentation for verification purposes (scanned or photo)
   e. Await review and verification (1-5 business days)
   f. Respond, if necessary, to requests for further information or requests for corrective action.

**DEADLINE: August 1**

### REQUIRED VACCINATIONS or PROOF OF IMMUNITY:

<table>
<thead>
<tr>
<th>Vaccination Type</th>
<th>Date of Dose #1:</th>
<th>Date of Dose #2:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles-Mumps-Rubella Vaccine</td>
<td>Month/Day/Year</td>
<td>Month/Day/Year</td>
</tr>
<tr>
<td>OR Positive Titer for measles (rubeola), mumps, and rubella</td>
<td>Measles Titer Result: _______ Mumps Titer Result: _______ Rubella Titer Result: _______</td>
<td>SUBMIT ALL TITER RESULTS</td>
</tr>
<tr>
<td>Varicella Vaccine</td>
<td>Month/Day/Year</td>
<td>Month/Day/Year</td>
</tr>
<tr>
<td>OR Positive Titer for Varicella</td>
<td>Varicella Titer Results: _______</td>
<td>SUBMIT ALL TITER RESULTS</td>
</tr>
<tr>
<td>OR Physician Documented Disease (chicken pox)</td>
<td></td>
<td>Date of Disease: Month/Day/Year</td>
</tr>
<tr>
<td>Meningococcal Vaccine - Quadrivalent</td>
<td>Date of Last Dose: Month/Day/Year</td>
<td>MD Signature: _______</td>
</tr>
<tr>
<td>Within the Past 5 Years</td>
<td></td>
<td>Select Type: Menactra ACWY Mencevax Nimenrix Menomune</td>
</tr>
<tr>
<td>ONLY IF LIVING IN CAMPUS HOUSING</td>
<td></td>
<td>Meneveo Mencevax</td>
</tr>
<tr>
<td>Campus housing includes all the undergraduate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>residential colleges and the following graduate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dormitories: 254 Prospect Street, 272 Elm Street, 276</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospect Street, Baker Hall, Harkness Dormitory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Medical School), and Helen Hadley Hall.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the student has lived or traveled outside the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States during the past year tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(TB) screening is REQUIRED</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Tuberculosis Skin Test (PPD)**

within the past 6 months

- OR QuantiFERON Lab Test
- OR Chest Xray
(if history of positive PPD)

<table>
<thead>
<tr>
<th>Test Type</th>
<th>Date of Test: Month/Day/Year</th>
<th>Result: _______ mm</th>
<th>Date of QuantiFERON Test: Month/Day/Year</th>
<th>Result: _______</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD Test</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QuantiFERON Lab Test</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest Xray</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Clinician Name** | **Clinician Signature** | **Date**

**Address** (Include city and state)

**Email** | **Telephone** | **Fax**
### RECOMMENDED VACCINES

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose Information</th>
<th>Select: Td or Tdap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus-Diphtheria-Pertussis</td>
<td>within the past 10 years</td>
<td>Date of Most Recent Dose: <strong>/</strong>/__ Month Day Year</td>
</tr>
<tr>
<td></td>
<td>Series of 2 doses</td>
<td>Date of Dose #1: <strong>/</strong>/__ Month Day Year</td>
</tr>
<tr>
<td>Hepatitis B Vaccine</td>
<td>Series of 3 doses</td>
<td>Date of Dose #1: <strong>/</strong>/__ Month Day Year</td>
</tr>
<tr>
<td>HPV Vaccine</td>
<td>Series of 3 doses</td>
<td>Date of Dose #1: <strong>/</strong>/__ Month Day Year</td>
</tr>
</tbody>
</table>
| Meningococcal B Vaccine       | □ Bexsero, series of 2 doses  
□ Trumenba, series of 3 doses | Date of Dose #1: __/__/__ Month Day Year | Date of Dose #2: __/__/__ Month Day Year | Date of Dose #3: __/__/__ Month Day Year |

<table>
<thead>
<tr>
<th>Clinician Name</th>
<th>Clinician Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Include city and state)</td>
<td>Email</td>
<td>Telephone</td>
</tr>
</tbody>
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