University of Hawai'i
University Health Services Mānoa
1710 East West Road, Honolulu, Hawai'i 96822
Phone 808-956-8965 Fax 808-956-3583
Secure email via File Drop: www.hawaii.edu/filedrop Recipient: UHSM

Dear Entering Student:

Welcome to University of Hawaiʻi at Mānoa! The University Health Services Mānoa (UHSM) is located on campus near the Kennedy Theater. A professional staff of physicians and nurses provide for the health needs of the students. UHSM has a general medical clinic for ambulatory care and specialty clinics by appointment, including women's health, sports medicine, dermatology, psychiatry, and nutritional counseling. We have a laboratory and pharmacy. Please visit our web site at http://www.hawaii.edu/shs to schedule an appointment or learn more about us.

HEALTH CLEARANCE REQUIREMENTS (Hawaiʻi Administrative Rules, DOH Title 11, Chapter 157)
The State of Hawaiʻi mandates that certain health requirements be met for entrance to post-secondary educational institutions. All students, including faculty/staff enrolled as students, must comply with health clearance requirements by completing the Health Clearance Form and Immunization Record and returning it by mail, fax or secure email to the Health Services. Please follow instructions for Tuberculosis Clearance and Immunization Requirements carefully. Observe the deadline - **You may not attend classes until you have received health clearance.**

1) TUBERCULOSIS (TB) CLEARANCE (Effective March 17, 2018)

U.S. Students: Complete the TB Risk Assessment Form and have your U.S. licensed healthcare provider (M.D., D.O., A.P.R.N., or P.A.) sign your completed form. A TB clearance needs to be obtained within twelve months prior to your start date or obtained on or after age sixteen. If your TB Risk Assessment is positive, a TB skin test, IGRA or CXR is required. Students with history of a positive PPD and negative chest x-ray must complete and return the Tuberculosis Symptom Screening form. This form can be found on our website: http://www.hawaii.edu/shs, under Forms and Memos.

Students Coming from Foreign Countries: The TB Risk Assessment Form must be completed and signed by a U.S. licensed healthcare provider (M.D., D.O., A.P.R.N., or P.A.). The U.S. licensed healthcare practitioner must document the state he/she is licensed and license number. The TB Risk Assessment Form may be completed upon arrival in Honolulu, at our University Health Services, the Hawai'i State Department of Health, or a private physician's office. If your TB Risk Assessment is positive, a TB skin test, IGRA or CXR is required.

Positive TB Risk Assessment Students: If you have recently taken the MMR vaccine (or any live vaccine), you must wait 4 weeks to take the TB skin test or TB blood test. A chest x-ray can be done to preliminarily complete the tuberculin requirement. The chest x-ray will allow you to register, however you are still required to have the TB skin test or blood test done 4 weeks after your MMR vaccine.

2) MEASLES, MUMPS, AND RUBELLA (MMR) IMMUNIZATIONS
Two doses of measles vaccine are required, with at least one of the two being an MMR (Measles, Mumps, and Rubella). First dose must have been given on or after 12 months of age and the second must have been given at least 4 weeks after the first dose. Measles, Mumps and Rubella immunizations may be waived if: 1) Student was born before 1957, or 2) provide laboratory evidence of immunity (positive antibodies) to Measles, Mumps, and Rubella.

The Hawai'i Department of Health has proposed adding "new" routinely recommended vaccinations to the list of required immunizations. Although not currently required for enrollment, these vaccines may soon be: a) Meningococcal, b) Tetanus/Diphtheria/Pertussis (Tdap), and c) Varicella . The Meningococcal vaccine is strongly recommended for college students, especially students who intend to live in the residence halls, as there is an increased risk of this highly contagious disease in this campus population. The serogroup B Meningococcal (MenB) vaccination should be considered; please discuss with your Healthcare Provider. Other vaccines highly recommended include: a) Polio, b) Human Papilloma Virus, and c) Hepatitis A and B.

Mail, fax, or secure email form(s) to:
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HEALTH CLEARANCE FORM

URGENT DEADLINES TO SUBMIT HEALTH FORMS: FALL SEMESTER: JULY 15 SPRING SEMESTER: DECEMBER 2

This information is treated confidentially. Please type or print answers in English using **black ink**.

NAME ____ UH STUDENT ID # ____________________
Last (Family Name) First Middle

DATE OF BIRTH ___/___/___ SEX: F ☐ M ☐ GENDER: F ☐ M ☐ T ☐ Q ☐ UH EMAIL ADDRESS ____________________

PERMANENT HOME ADDRESS ____
Street

____ TELEPHONE (____)____________________
City State Zip Code Area Code

LOCAL ADDRESS ____
Street City State Zip Code

TELEPHONE (____)____________________ CELL PHONE (____)____________________
Area Code Area Code

EXPECTED DATE OF ENROLLMENT ___/___/___ PREVIOUSLY ENROLLED AT ANY OTHER UH INSTITUTION? NO ☐ YES ☐ Year:_____

IN CASE OF EMERGENCY NOTIFY ______________________________ RELATIONSHIP ____________________

PHONE (H) (_____)____________________(W) (_____)____________________(CELL)(_____)____________________

DO YOU HAVE ANY SIGNIFICANT MEDICAL CONDITIONS OR DISABILITIES THAT WOULD LIMIT PARTICIPATION IN ACADEMIC AND/OR PHYSICAL ACTIVITIES? (Specify)

______________________________ Drug Allergy ______________________________

PERSONAL HEALTH CLEARANCE INFORMATION - I hereby authorize the release of my health clearance information to other campuses within the University of Hawai'i System to be used for enrollment and transfer purposes between UH campuses.

____

SIGNATURE OF STUDENT (Parental signature required if under 18) DATE

AUTHORIZATION AND CONSENT FOR TREATMENT OF MINORS - To be completed by a parent or guardian if the student will be under the age of 18 when seeking health services from the University of Hawai'i.

I, the parent/legal guardian of (PRINT STUDENT NAME)______________________________, in consideration of the services rendered and of the facilities provided by the University of Hawai'i Health Services, hereby voluntarily and knowingly authorize and give my express consent to visit, or visits when either unaccompanied or accompanied
by myself or another adult while in transit to, from, or in attendance at the University of Hawai'i, for the purpose of clinical observation, and/or the administration of such treatment, and the taking of whatever X-Rays, injections, or drugs that may be considered necessary or desirable in the observation, diagnoses, and treatment of his/her case by the physician in attendance and/or the staff of the University of Hawai'i Health Services.

____

SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

MANDATORY HEALTH REQUIREMENTS (PART 1 & 2)

YOU MAY NOT ATTEND CLASSES UNTIL THESE REQUIREMENTS ARE MET

The State of Hawai'i mandates that certain health requirements be met for entrance to post-secondary educational institutions. (Hawai'i Administrative Rules, DOH Title 11, Chapter 157)

MAIL, FAX, OR SEND SECURE EMAIL TO:
UNIVERSITY HEALTH SERVICES MANOA
1710 East West Road, Honolulu, Hawaii 96822
FAX: 808-956-3583 PHONE: 808-956-8965
SECURE EMAIL VIA FILEDROP:
https://www.hawaii.edu/filedrop/
Recipient: UHSM

Name ______________________________ **UH ID#** ____________________ **Birthdate** ______________
Last (Family Name) First Month/Day/Year

PART I of 2 REQUIRED: TUBERCULOSIS CONTROL

Complete this TB Risk Assessment (circle Yes or No) and have your US Licensed Healthcare Provider sign completed form. A TB clearance needs to be obtained within twelve months prior to your start date or obtained on or after age sixteen.

If you have a history of a positive PPD and negative chest x-ray, complete and return the Tuberculosis Symptom Screening Form. This form may be found on our website: http//www.hawaii.edu/shs under Forms and Memos.

Yes* No	1. Do you have a cough that has lasted for 3 weeks or longer?
Yes* No	2. Were you born in a country **other than** the United States, Canada, Australia, New Zealand, or Western and North European countries? List country:
Yes* No	3. Have you lived in or traveled to (for 4 or more weeks) a country **other than** the United States, Canada, Australia, New Zealand, or Western and North Europe? List country:
Yes* No	4. At any time, have you been around someone who was sick with *TB disease*? Do not check "Yes" if exposed only to someone with a positive TB skin test (latent TB infection).
Yes* No	5. Do you have a health problem or do you plan to be on medical treatment that may affect the immune system? Includes HIV/AIDS, organ transplant, treatment with TNF-alpha antagonist (ex: Humira, Enbrel, Remicade) or steroid medication for a month or longer.

IF THE ANSWER TO ALL OF THE ABOVE QUESTIONS IS NO, HAVE YOUR U.S. LICENSED HEALTHCARE PROVIDER SIGN FORM. GO ON TO PART II REQUIRED MEASLES (RUBEOLA), MUMPS, AND RUBELLA (GERMAN MEASLES) OR MMR.

***IF THE ANSWER IS YES TO ANY OF THE ABOVE QUESTIONS THE FOLLOWING IS REQUIRED**:

- Have a Tuberculin skin test (TST) **OR** Tuberculosis blood test (QFT, T-Spot) done:
  - Testing must be done by a U.S. licensed healthcare provider (M.D., D.O., N.D., A.P.R.N., or P.A.) and within ONE year prior to initial attendance.
  - The TST interpretation should be based on mm of induration as well as risk factors. **Negative and 4 days readings are NOT accepted.** A **positive** TB skin test requires a chest x-ray. A **positive or borderline** IGRA test requires a chest x-ray.
  - If the test was done in a foreign country, a U.S. licensed healthcare provider must document the U.S. state and number in which they are licensed AND the TB test solution used must be FDA approved, either Tubersol or Aplisol.
- **UPON COMPLETION OF PART I, have your US Licensed Healthcare Provider sign form and GO ON TO PART II: REQUIRED: MEASLES (RUBEOLA), MUMPS, AND RUBELLA (GERMAN MEASLES).**

TB Test: ☐Tubersol or ☐Aplisol Date Given: ____________ Date Read (48-72 hours): ____________ Results (in mm): ______

IGRA: ☐QFT or ☐T-Spot Date: ________________ **Result** (circle one): Negative Positive Borderline Indeterminate/Invalid

CHEST X-RAY (if TST or IGRA is positive) Date: ________________________ Results: ____________________

Name of Physician/Healthcare Provider **U.S. State & license number (*TB done in Foreign Country)** **Signature** **Date**

Address **City** **State** **Zip Code**

Name ____ **Birthdate** _____________________ **UH ID#** _______________

PART II REQUIRED: MEASLES (RUBEOLA), MUMPS, AND RUBELLA (GERMAN MEASLES) OR MMR

Two doses of live Measles vaccine with at least one being an MMR vaccine is required for students born after 1956. Dose one must have been given on or after age 1. Dose two must have been given at least 4 weeks after the first dose. **Complete ONE of the following**:

1. MMR vaccines #1: _________________________ #2: _______________________

   OR

2. Measles vaccine date: ____________________ AND MMR date: _________________

   Mumps vaccine date: ____________________

   Rubella vaccine date: ____________________

   OR

3. Antibody titer results: Measles date: ____________________ Circle results: Positive / Negative / Equivocal

   Mumps date: ____________________ Circle results: Positive / Negative / Equivocal

   Rubella date: ____________________ Circle results: Positive / Negative / Equivocal

PART III HIGHLY RECOMMENDED VACCINES

Vaccine	Vaccination Dates		
Hepatitis A	#1	#2	
Hepatitis B	#1	#2	#3
Human Papillomavirus (HPV)	#1	#2	#3
Meningococcal Quadrivalent	#1		
Serogroup B Meningococcal (MenB)	#1	#2	#3 (if needed)
Polio	Initial series:		Booster:
Tetanus/Diphtheria/Pertussis (Td and/or Tdap)	Tdap date:	Td series:	
Varicella (Chicken Pox)	Vaccine date #1 & #2	Titer date and result (+/-):	Disease date:

Submit one or more of the following as acceptable proof of immunizations:

1. Completion of this form, by a healthcare provider, with the provider's name, address, phone number and signature. Include healthcare provider U.S license state and license number if coming from a foreign country.
2. A copy of a school or public health immunization record.
3. A copy of a healthcare provider's record.

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Name of Physician/Healthcare Provider **U.S. State & license number** **(*TB done in Foreign Country)** **Signature** **Date**

____

Address **City** **State** **Zip Code**

TB Document J: State of Hawaii List of High Risk Countries

Hawaii State Department of Health
Tuberculosis Control Program

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia - Herzegovina
Botswana
Brazil
Brunei
Bulgaria
Burkina
Burundi
Cambodia
Cameroon
Cape Verde
Central African Rep.
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d'Ivoire
Darussalam
Dem. People's Rep. of Korea
Dem. Rep. of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Faso
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Dem. Rep.
Latvia
Lesotho
Liberia
Libyan
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Fed. States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Puerto Rico
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent - Grenadines
Sao Tome and Principe
Senegal
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Thailand
The Former Yugoslav
Timor-Leste
Togo
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Turks and Caicos Islands
Tuvalu
Uganda
Ukraine
United Rep. of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela
Viet Nam
Wallis and Futuna Islands
Yemen
Zambia
Zimbabwe

High-incidence countries include any country with an annual TB rate over 20/100,000.
Source: http://www.who.int/tb/country/data/download/en/
Revised May2018.

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HEALTH INSURANCE

If you do not have health insurance, we highly recommend that all students obtain coverage. Health insurance is mandatory for international students and students enrolled in specific programs.

The University Health Service can bill many non-HMO insurance companies for services provided at UHSM. (There are some exceptions, and we do not bill Med-QUEST, listed below.) Although you do not need to have insurance to use the on-campus health services, you will be asked to provide insurance coverage information when you visit. To expedite the clinic registration process, please return the completed Insurance Information Form and a front and back copy of your medical insurance card to:

University Health Services Mānoa
1710 East West Rd.
Honolulu, HI 96822

At the Health Service, charges for uninsured students are reasonable; however, costs for off-campus care, emergencies, and hospitalization can be extremely high. We highly recommend that you obtain insurance to cover these situations.

HOW TO OBTAIN HEALTH INSURANCE COVERAGE

1) Students who have coverage through their parents' employee health plans:
Under the Affordable Care Act (www.healthcare.gov), young adults will be allowed to stay on their parents' plan until they turn 26 years old (some exceptions may apply). Contact your insurance provider for specifics.

2) Students who wish to purchase their own health insurance coverage:
University of Hawai'i endorsed student health insurance plans are available for regular registered students. The current plans are provided by Hawaii Medical Services Association (HMSA). The coverage terms and premiums are very favorable. Please see our website for details. Application forms are available at the University Health Services or can be downloaded from the HMSA website at www.hmsa.com/portal/student.

3) Students who may qualify for the State of Hawai'i Med-QUEST plan:
Med QUEST is a State health insurance plan for those who meet low-income criteria. For more information, please visit the Department of Human Services, Med QUEST website: http://humanservices.hawaii.gov/mqd/

4) Out-of state students and students who have non- Hawai'i or foreign insurance plans:
Please review carefully the terms of your health insurance coverage. Your insurance may not cover medical services performed away from your home location and/or designated medical facilities or providers.
IMPORTANT for International Students: The University requires that all international students maintain adequate medical health insurance and medical evacuation and repatriation coverage while attending UH. For F-1 students, go to http://www.hawaii.edu/shs for more information. For all other international students, go to the office that handles your visa for more information.

Please feel free to visit the University Health Services at 1710 East West Road. We will be happy to answer any questions you may have concerning your health care needs on campus. Telephone 808-956-8965. You may also visit our web site at http://www.hawaii.edu/shs. For questions on the UH Student Plan, you may also contact the Student Health Insurance Office at shio@hawaii.edu.

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HEALTH INSURANCE INFORMATION SHEET

1) PATIENT INFORMATION

NAME: Last	First	Middle	UH ID#	
DATE OF BIRTH: / / (MM DD YY)	SEX: GENDER:		UH EMAIL ADDRESS:	
Local Address	City :	State:	Zip code:	Phone: ( )
Permanent address:	City:	State:	Zip code:	Phone: ( )
Employer:				
Address:			Phone: ( )	
EMERGENCY CONTACT:	Relationship:	Phone: (Home) ( )	Phone: (Work / Cell) ( )	

2) PRIMARY INSURANCE COMPANY: Please attach copy of card (front and back)

Name of Insurance:	Policy or ID#:	Group #:	
Subscriber:	Subscriber Date of Birth:	Plan #:	Cov. Code:
Subscriber Address:	City:	State:	Zip code:
Name of Primary Care Provider:	Phone: ( )	Effective Date:	Expiration Date:
Relationship to Subscriber: child (s) spouse (p) self (s) other (o)			

For HMSA subscribers only. Choose UHSM to be your primary care provider: ☐ Yes ☐ No

3) SECONDARY INSURANCE COMPANY: Please attach copy of card (front and back)

Name of Insurance:	Policy or ID#:	Group #:	
Subscriber: :	Subscriber Date of Birth:	Plan #:	Cov. Code:
Subscriber Address: City: State: Zip code:	Effective Date:	Expiration Date:	
Relationship to Subscriber: child (s) spouse (p) self (s) other (o)			

INSURANCE CARRIER:
I hereby authorize release of information necessary to file a claim with my insurance company and **ASSIGN BENEFITS OTHERWISE PAYABLE TO ME, TO THE UNIVERSITY OF HAWAIʻI AT MANOA, UNIVERSITY HEALTH SERVICES AS INDICATED ON THE CLAIM**.
I understand I am financially responsible for any balance not covered by my insurance carrier.

Signature of Patient (Parental signature required if under 18) Date

APPOINTMENT REMINDERS VIA TEXT:
I consent to receive text message reminders from **UNIVERSITY HEALTH SERVICES MANOA** at the phone number provided, including my wireless number. I understand that I may be charged for such messages by my wireless carrier and that such messages may be generated by an automated messaging system, and that I may opt-out of this service at any time.

Signature of Patient (Parental signature required if under 18) Mobile Number Mobile Carrier Date