HEALTH IMMUNIZATION CLEARANCE FORM

PRINT CLEARLY WITH DARK BLACK INK.
This form will be read by a computer.
Upload to medproctor.com

The State of Hawai'i Department of Health (DOH) Hawai'i Administrative Rules, Title 11 (Chapter 157 and 164.2) requires certain health requirements be met for attendance to a post-secondary institution. Health clearances must bear the signature of the practitioner, stamp, or imprinted name of the department or practitioner or name of licensed facility. A practitioner is a physician, advanced practice registered nurse (APRN), or physician assistant (PA) licensed to practice in the United States. ***This form may be rejected if it is not signed by a U.S. licensed medical practitioner.***

UH Campus: _____ UH ID: _____ Term: _____

Student Name: _____ DOB: _____ Phone/Cell #: _____

Are you an International Student: ☐ Yes ☐ No *Living on a UH campus: Yes ☐ No ☐

This form has been completed to the best of my knowledge, and I freely consent to this information being used for the purposes of registration at the University of Hawai'i.

Student Signature _____ Date (MM/DD/YYYY) _____

Section A: IMMUNIZATIONS *(To be completed by U.S. licensed medical practitioner.)*

Immunizations shall include the complete date the vaccine was administered. All immunizations must meet the minimum ages and minimum intervals between doses. For more information on Religious or a Medical Exemption visit: https://www.hawaii.edu/health-clearance/.

MMR (Measles, Mumps, Rubella) 2 doses: 1st Dose _____ (Month Day Year) 2nd Dose _____ (Month Day Year)
*Note: Mumps titers are NO longer accepted for proof of immunity.

EXCEPTION: ☐ Check here if born before 1957

PRINT NAME OF LICENSED MEDICAL PRACTITIONER _____ SIGNATURE OF LICENSED MEDICAL PRACTITIONER _____ DATE _____

U.S. State & License Number _____ Healthcare Facility _____

TDaP (Tetanus-diphtheria-acellular pertussis) 1 dose: 1st Dose: _____ (Month Day Year)

Note: Valid TDaP dose must be administered on or after 10 years of age. Do not confuse with DTaP (administered to children 0-6 years of age). TDaP was licensed for use in the U.S. in 2005. Doses recorded as "TDaP"with an administration date in the U.S. prior to 2005 should not be counted.

PRINT NAME OF LICENSED MEDICAL PRACTITIONER _____ SIGNATURE OF LICENSED MEDICAL PRACTITIONER _____ DATE _____

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VARICELLA (Chicken Pox) 2 doses: 1st Dose: _____ (Month Day Year) 2nd Dose: _____ (Month Day Year)
*Note: Titers are NO longer accepted for proof of immunity.

EXCEPTION: ☐ Check here if born in the U.S. before 1980 ☐ Check here if history of Varicella disease or Herpes Zoster (Mo/Year): _____

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Section B: IMMUNIZATION FOR ON-CAMPUS HOUSING

*Required for new students to the institution planning to live in on-campus housing who are 21 years of age or younger.

MENINGOCOCCAL (MCV) (Tetanus-diphtheria-acellular pertussis) 1 dose: 1st Dose: _____
(At least 1 dose, on or after the age of 16 years.) Month Day Year

PRINT NAME OF LICENSED MEDICAL PRACTITIONER | SIGNATURE OF LICENSED MEDICAL PRACTITIONER | DATE

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Section C: TUBERCULOSIS (TB) CLEARANCE *(To be completed by U.S. licensed medical practitioner.)*

The student has been evaluated using the process set out in the State of Hawai'i DOH TB Clearance Manual and determined that the individual does not have TB disease as defined in section 11-164.2-2, Hawai`i Administrative Rules.

Please complete ONE of the following:

1) ☐ State of Hawai'i Department of Health TB Screening/Risk Assessment Clearance Form F (page 3 below). (If completed and cleared, Form must be attached)

TB Screening Date: _____ NNegative TB risk assessment ☐
Month Day Year

2) ☐ PPD Skin Test: _____ _____ Negative Test for TB Infection ☐
Month Day Year Induration (mm)

(Note: The skin test must be read 48-72 hours after administration and must be documented in millimeters (mm).

3) ☐ Quantiferon Gold Test/Blood Test Result: _____ Positive ☐ Negative ☐
Month Day Year

4) ☐ Negative Chest X-Ray: _____
Month Day Year

This TB clearance provides a reasonable assurance that the individual was free from tuberculosis disease at the time of the exam. This does not imply any guarantee or protection from future tuberculosis risk for the individual listed.

PRINT NAME OF LICENSED MEDICAL PRACTITIONER | SIGNATURE OF LICENSED MEDICAL PRACTITIONER | DATE

U.S. State & License Number | Healthcare Facility

TB Document F: State of Hawaii TB Clearance Form

Hawaii State Department of Health
Tuberculosis Control Program

Patient Name	DOB	TB Screening Date

I have evaluated the individual named above using the process set out in the DOH TB Clearance Manual dated 2/10/17 and determined that the individual does not have TB disease as defined in section 11-164.2-2, Hawaii Administrative Rules.

Screening for schools, child care facilities or food handlers *(TB Document A or E)* (Complete this section)
☐ Negative TB risk assessment
☐ Negative test for TB infection
☐ Positive test for TB infection, and negative chest X-ray

Initial Screening for health care facilities or residential care settings (*TB Document B or C)*
☐ Negative test for TB infection (2-step)
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, negative CXR within previous 12 months, and negative symptom screen
☐ Previous positive test for TB infection, and negative CXR

Annual Screening for Health care facilities or residential care settings (*TB Document D)*
☐ Negative test for TB infection
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, and negative symptoms screen
☐ Previous positive test for TB infection, and negative CXR

Signature or Unique Stamp of Practitioner: _____

Printed Name of Practitioner: _____

Healthcare Facility: _____

This TB clearance provides a reasonable assurance that the individual listed on this form was free from tuberculosis disease at the time of the exam. This form does not imply any guarantee or protection from future tuberculosis risk for the individual listed.