❑ Fall 20 ___________

❑ Spring 20_________

❑ Summer 20_______

UNIVERSITY *of* HAWAIʻI
SYSTEM

UH Hilo - Student Medical Services
Campus Center, Room 212
200 W. Kawili St. Hilo, HI 96720

Phone: (808) 932-7369 Fax: (808) 932-7368
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HEALTH IMMUNIZATION CLEARANCE FORM

The State of Hawaiʻi Department of Health (DOH) Hawaiʻi Administrative Rules, Title 11 (Chapter 157 and 164.2) requires certain health requirements be met for attendance to a post-secondary institution. Registration is not allowed until all health clearances are met and submitted to the Admissions and Records Office. 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 fully completed and signed in both sections by a U.S. licensed medical practitioner.***

NAME: Birth Date: UH ID:
Print Student Last Name, First Name MI

Are you an international student:
Yes No

Phone Number: Address:

TUBERCULOSIS (TB) CLEARANCE

I have evaluated the individual named above using the process set out in the State of Hawaiʻi 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.

TB Screening Date: ____/____/_______________

❑ Negative TB risk assessment

Positive test for TB infection, and negative chest x-ray

Negative IGRA (QuantiFERON / T-SPOT) blood test

❑ Negative test for TB infection

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.

Signature or Stamp of Practitioner: Date: ___/___/__________

Print Name of Practitioner: Healthcare Facility:

IMMUNIZATION

Immunizations shall include the complete date the vaccine was administered. All immunizations must meet the minimum ages and minimum intervals between doses. For a Religious exemption, see the Admissions and Records Office for the appropriate exemption form. For Medical Exemptions, see a U.S. licensed practitioner. Please refer to the Hawai'i Department of Health for guidelines on Immunization Requirements and Exceptions to these requirements.

1) **Tdap (Tetanus-diphtheria-acellular pertussis) 1 dose: Date: ___/___/_______**
   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.

2) **MMR (Measles, Mumps, Rubella) 2 doses:** **Dose 1 Date: ___/___/________** **Dose 2 Date: ___/___/________**
   Note: Mumps titers are no longer accepted for proof of immunity
   Exceptions: Born before 1957

3) **Varicella (chickenpox) 2 doses:** **Dose 1 Date:** ____/____/_______ **Dose 2 Date:** ____/____/________
   Exceptions: History of Varicella disease or Herpes Zoster ____/________
   ❑ Born in U.S. before 1980

Signature of Practitioner: Date: ___/___/____________

Printed Name/Stamp of Practitioner: Healthcare Facility:

Office Use Only: ❑TB ❑ TB15 ❑ MR ❑ VC ❑ TD MCV ❑GOAMEDI ❑SOAHOLD ❑OnBase

Addt'l Notes:

COMPLETE PAGE TWO OF THIS FORM IF APPLICABLE

HEALTH CLEARANCE FORM (page 2)

NAME:____Birth Date:___________UH ID:______________
Print: Student Last Name, First Name MI

COMPLETE ONLY IF STUDENT WILL BE LIVING IN ON-CAMPUS HOUSING

❑ Yes ❑ No Student will be residing in on-campus housing

❑ Yes ❑ No This is the student's first time at this institution and is 21 years or younger

If yes to both, please provide Meningococcal Conjugate (MCV) immunization date: _____/_____/__________ (at least 1 dose, on or after the age of 16 years)

Signature or Stamp of Practitioner:____Date:______________________

Print Name of Practitioner:_______________________________Healthcare Facility:______________________________

COMPLETE ONLY IF STUDENT (UNDER THE AGE OF 18) WILL BE SELECTING TO RECEIVE HEALTHCARE SERVICES FROM ON-CAMPUS HEALTH FACILITY
(UH Mānoa, UH Hilo, Maui College, Leeward CC)

To be completed by Parent or Legal Guardian if the student is under the age of 18 when seeking health services from the University.

I, the parent/legal guardian of____(print student’s name), in consideration of the services rendered by the University of Hawai’i *Health Center*, hereby voluntarily and knowingly, authorize and give my express consent to the *Health Center* for the administration of TB tests, immunizations, medical treatment for illnesses or injuries, and emergency care to the above-named student as deemed necessary by the *Health Center* staff.

Parent/Legal Guardian Signature:____Date:______________________

Print Last Name, First Name:____