



University of Hawai'i
University Health Services Mānoa
1710 East West Road, Honolulu, Hawai'i 96822
Phone 808-956-8965 Fax 808-956-3583
Upload documents to your Patient Access Portal:
<https://healthservices.hawaii.edu>

Dear Entering Student:

Welcome to University of Hawai'i 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 (Hawai'i Administrative Rules, DOH Title 11, Chapter 157)

The State of Hawai'i 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 Forms and returning by mail, fax or secure email to the Health Services. Health clearances must bear the signature of the U.S. licensed practitioner, stamp, or imprinted name of the 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. Observe the deadline **You may not attend classes until you have received health clearance.**

1) TUBERCULOSIS (TB) CLEARANCE (REQUIRED)

- A TB Clearance needs to be obtained within twelve months prior to your course start date or obtained on or after age sixteen.
- A TB skin test must be done by a U.S. licensed practitioner & FDA approved.
- If your TB skin test is positive, a chest x-ray is required and must be done a U.S. licensed practitioner.
- A negative result on a U.S. FDA approved IGRA blood test (QuantiFERON Gold or T-SPOT) will also be accepted. Laboratory test results must be attached.

2) IMMUNIZATION CLEARANCE (REQUIRED)

☐ MEASLES, MUMPS, AND RUBELLA (MMR) VACCINES:

- Two MMR vaccines are required. Titers are no longer acceptable.
- If you are born before 1957, you are exempt from the MMR requirement.

☐ TDAP (TETANUS, DIPHTHERIA, ACELLULAR PERTUSSIS) VACCINE:

- Must be administered on or after age 10 and be a Tdap vaccine.

☐ VARICELLA (CHICKEN POX) VACCINE: Two Varicella vaccines are required.

- If you had the Varicella disease, your U.S. licensed practitioner must document & sign the date of disease. If you were born in the U.S. before 1980, you are exempt from the Varicella requirement.

☐ MENINGOCOCCAL CONJUGATE VACCINE (A, C, Y, W-135) is required for first-year college students living in on-campus housing who are age 16 through 21. **You will not be allowed to check into your on-campus housing without documentation.**

HIGHLY RECOMMENDED VACCINATIONS (PLEASE DISCUSS WITH YOUR HEALTHCARE PROVIDER):

1. Hepatitis A & B
2. Serogroup B Meningococcal (MenB)
3. Polio
4. HPV
5. COVID-19

- Fall 20 _____
- Spring 20 _____
- Summer 20 _____



UNIVERSITY of HAWAI'I
SYSTEM

HEALTH IMMUNIZATION CLEARANCE FORM

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. 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:
Phone Number: _____ Address: _____ Yes No

TUBERCULOSIS (TB) CLEARANCE

I have evaluated the individual named above 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.

TB Screening Date: ____/____/____
 Negative TB risk assessment
Positive test for TB infection, and
Negative IGRA (QuantiFERON /
infection T-SPOT) blood test (Lab test
must be attached)
Negative chest x-ray
Negative test for TB

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

Add'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 a Parent or Legal Guardian of a student under the age of 18 seeking health services from University Health Services Manoa (UHSM).

I, the parent/legal guardian of _____ (print student's name), in consideration of the services rendered by the University Health Services Manoa, hereby voluntarily and knowingly, authorize and give my express consent to UHSM 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 UHSM staff.

Parent/Legal Guardian Signature: _____ Date: _____
Print Last Name, First Name: _____



TB Document G: State of Hawaii TB Risk Assessment for Adults and Children

Hawaii State Department of Health
Tuberculosis Control Program

1. Check for TB symptoms

- If there are significant TB symptoms, then further testing (including a chest x-ray) is required for TB clearance.
- If significant symptoms are absent, proceed to TB Risk Factor questions.

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does this person have significant TB symptoms? Significant symptoms include <u>cough for 3 weeks or more</u>, plus at least one of the following:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Coughing up blood</td> <td style="width: 33%;"><input type="checkbox"/> Fever</td> <td style="width: 33%;"><input type="checkbox"/> Night sweats</td> </tr> <tr> <td><input type="checkbox"/> Unexplained weight loss</td> <td><input type="checkbox"/> Unusual weakness</td> <td><input type="checkbox"/> Fatigue</td> </tr> </table>	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Fever	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Unusual weakness	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Fever	<input type="checkbox"/> Night sweats					
<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Unusual weakness	<input type="checkbox"/> Fatigue					

2. Check for TB Risk Factors

- If any “Yes” box below is checked, then TB testing is required for TB clearance
- If all boxes below are checked “No”, then TB clearance can be issued without testing

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Was this person born in a country with an elevated TB rate? Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Has this person traveled to (or lived in) a country with an elevated TB rate for four weeks or longer?</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>At any time has this person been in contact with someone with <i>infectious TB disease</i>? (Do not check “Yes” if exposed only to someone with latent TB)</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the individual have a health problem that affects the immune system, or is medical treatment planned that may affect the immune system? (Includes HIV/AIDS, organ transplant recipient, treatment with TNF-alpha antagonist, or steroid medication for a month or longer)</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>For persons under age 16 only: Is someone in the child’s household from a country with an elevated TB rate?</p>
<p>Provider Name with Licensure/Degree:</p>	
<p>Person's Name and DOB:</p>	
<p>Assessment Date:</p>	
<p>Name and Relationship of Person Providing Information (if not the above-named person):</p>	



TB Document J: State of Hawaii List of High Risk Countries
Hawaii State Department of Health Tuberculosis Control Program

7/18/2017

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