

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



UNIVERSITY of HAWAI'I
SYSTEM

HEALTH 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 Last Name, First Name MI

Student's Signature: _____ Date: _____

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

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

Immunization shall include the complete date the vaccine was administered, recorded as month/day/year. All immunizations must meet minimum ages and minimum intervals between doses. For Religious exemption, see the Admissions and Records Office for appropriate exemption form. For Medical Exemption, see a U.S. licensed practitioner.

MMR (Measles, Mumps, Rubella) 2 doses: Date: ___/___/____ Date: ___/___/____
 Born before 1957 (exempt from MMR)

Varicella (chickenpox) 2 doses: Date: ___/___/____ Date: ___/___/____
 History of Varicella disease Date: ___/___/____
 Born in U.S. before 1980 (exempt from Varicella)

Tdap (Tetanus-diphtheria-acellular pertussis) 1 dose: Date: ___/___/____

Signature of Practitioner: _____ Date: _____

Printed Name/Stamp of Practitioner: _____ Healthcare Facility: _____

~~~~~ FOR OFFICE USE ONLY ~~~~~

TB     TB15     MR     VC     TD       GOAMEDI     SOAHOLD     OnBase

**COMPLETE PAGE TWO OF THIS FORM IF APPLICABLE**

**HEALTH CLEARANCE FORM (page 2)**

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

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

- Yes  No Residing in on-campus dorm  
 Yes  No First-year student age 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: \_\_\_\_\_

**AUTHORIZATION**

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 and to comply with the State of Hawai'i Department of Health (DOH) Hawai'i Administrative Rules, Title 11 (Chapter 157 and 164.2).

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Signature if student age 17 or younger: \_\_\_\_\_ Date: \_\_\_\_\_