Mail, fax, or filedrop form to: University of Hawai'i Maui College Admissions & Records 310 W. Ka'ahumanu Ave, Kahului, HI, 96732
Phone: (808) 984-3267 Fax:(808) 984- 3872 Filedrop: https://www.hawaii.edu/filedrop Recipient: mauclear@hawaii.edu

☐ **Fall 20** _____
☐ **Spring 20**_____
☐ **Summer 20**_____

Print Form

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 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:** ___/___/_____

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 Date: ___/_____
☐ Born in U.S. before 1980

Signature of Practitioner: _____ Date: ___/___/_____

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

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

☐TB ☐TB15 ☐MR ☐VC ☐TD ☐MCV ☐GOAMEDI ☐SOAHOLD ☐OnBase
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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:_____

Save Form