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

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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 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.

MMR (Measles, Mumps, Rubella) 2 doses:
Note: Mumps titers are no longer accepted for proof of immunity

Dose 1 Date: _____ Dose 2 Date: _____

Exceptions: ☐ Born before 1957

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

Tdap (Tetanus-diphtheria-acellular pertussis) 1 dose: Date: _____

Signature of Practitioner: _____ Date: _____

Print Name of Practitioner: _____ Healthcare Facility: _____

---------- FOR OFFICE USE ONLY ----------

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