MANDATORY HEALTH REQUIREMENTS

The State of Hawai'i mandates that certain health requirements be met for entrance to post-secondary educational institutions (Hawai'i Administration Rules, DOH Title 11, Chapter 157).

YOU MAY NOT REGISTER UNTIL THESE REQUIREMENTS ARE MET.

MAIL OR FAX TO:
University of Hawai'i at Hilo
STUDENT MEDICAL SERVICES
200 W. Kawili St.,
Hilo, HI 96720-4091
PHONE: (808) 932-7369
FAX: (808) 932-7368

Name _____ Birthdate _____ UH ID # _____
Last (Family Name) First

I. TUBERCULOSIS CONTROL:

U.S. STUDENTS: A Tuberculin skin test (PPD - Mantoux) and, if positive, a chest x-ray by a U.S. licensed healthcare provider (M.D., D.O., A.P.R.N., or P.A.) within one year prior to initial attendance is required. Quantiferon tests are not accepted.

INTERNATIONAL STUDENTS: All students must have a TB skin test by a U.S. licensed healthcare provider (M.D., D.O., A.P.R.N., or P.A.) within one year prior to enrollment. (The TB test may be done in a foreign country if the healthcare provider documents their U.S. State and medical license number.*) Submit this form with only the MMR dates, and upon arrival on campus, our Student Medical Services clinic will administer TB tests. If positive, a chest x-ray is required.

RETURNING or TRANSFERRING STUDENTS from a POST-SECONDARY SCHOOL in HAWAII: Students with a history of positive PPD and negative chest x-ray must complete and return the Tuberculosis Symptom Screening Form. This form can be found on our website at www.hilo.hawaii.edu/studentaffairs/health/

TB Test/PPD/MANTOUX: Date Given _____ Date Read _____ Results (in mm) _____
("Negative" not acceptable)

CHEST X-RAY (if skin test is positive): Date taken _____ Results _____

II. MEASLES (Rubeola), MUMPS, RUBELLA (German Measles):

Two doses of live measles-containing vaccine, with at least one being an MMR is required of students born after 1956. Dose 1 must have been given on/after 12 months-of-age and after January 1, 1968. Dose 2 must have been given at least 28 days after the first dose.

Complete ONE of the following:

1) 2 MMR immunizations.....Date 1) _____ /_____ /_____ 2) _____ /_____ /_____

2) 1 MMR.....Date 1) _____ /_____ /_____
1 Measles vaccine.....Date 1) _____ /_____ /_____

3) Antibody Titers.....Measles.....Date _____ /_____ /_____ Circle results: Pos / Neg / Equiv
Mumps.....Date _____ /_____ /_____ Circle results: Pos / Neg / Equiv
Rubella.....Date _____ /_____ /_____ Circle results: Pos / Neg / Equiv

4) Disease Dates _____ Measles _____ Mumps _____ Rubella

OPTIONAL IMMUNIZATIONS	Not required, but highly recommended	Initial Date	Booster	Booster	Booster
	Hepatitis A				
	Hepatitis B				
	Human Papillomavirus Vaccine				
	Meningococcal				
	Polio				
	Tetanus/Diphtheria/Pertussis				
	Varicella				

Submit **one or more** of the following as acceptable proof of immunizations:

1) Completion of this form by a **healthcare provider** including the provider's name, address, phone number and **signature** at the bottom OR
2) A copy of a school or public health immunization record OR
3) A copy of a healthcare provider's record.

*U.S. State license number of healthcare provider for TB tests done in foreign countries

_____
U.S. State license number

Name of Physician/Clinician **Signature of Physician/Clinician** **Date** **Phone**

Address **City** **State** **Zip Code**

HEALTH HISTORY FORM

This information is confidential and does not become part of your academic record.

Name _____ UH ID # _____
Last (Family Name) First Middle

Date of Birth ____/____/____ Gender: ❑ F ❑ M Phone # (_____) _____
Month Day Year Area Code

Permanent Address _____
Street City State/Zip Home Phone #

Local Address _____
Street City State/Zip Home Phone #

Student Type:

❑ First-time ❑ International _____ (Country)
❑ Returning to UHH: Last attended _____ Sem/Year
❑ Transfer from _____ (College)
Last attended _____ Sem/Year

Email _____

Expected date of enrollment:
❑ Fall ❑ Spring _____ Year

Authorization and Consent for Treatment of Minors

To be completed by Parent or Guardian if the student will be 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 at Hilo Student Medical Services (hereafter UHHSMS), hereby voluntarily and knowingly, authorize and give my express consent to the UHHSMS 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 UHHSMS staff.

_____
SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

In Case of Emergency, Notify:

Name _____
Last (Family Name) First Relationship

Address _____
Street City

_____ Phone (____) _____
State Zip Code Area Code

Name, Address, & Phone # of Personal Physician:

_____

_____

_____

Personal History

Have you had:	Y	N	Allergic to (list others):	Y	N	Surgery (specify):	Current Medications:
Measles Disease (rubeola)			Aspirin				
German Measles Disease			Penicillin				
Mumps Disease			Sulfa				
Chicken Pox							
Malaria							
Tuberculosis							

Please elaborate on all "yes" answers.

A. Has your physical activity been restricted during the past five years? (Give reasons and durations.)

B. Have you received treatment or counseling for an alcohol, drug-related or emotional problem? (Give details.)

C. Do you have a history of any severe or chronic condition? (Give details)

D. Do you have any pre-existing medical conditions we should be aware of? (Give details)

Signature of Student **Date**

Revised 5/21/2014