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.

DEADLINES: FALL SEMESTER-JULY 1 SPRING SEMESTER-DECEMBER 1

I. TUBERCULOSIS CONTROL:

U.S. STUDENTS: A Tuberculin skin test (PPD - Mantoux) OR 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. If the skin test is positive, a chest x-ray is required.

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/

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

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.

OPTIONAL IMMUNIZATIONS

Not required, but highly recommended

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<tr>
<th>Immunization</th>
<th>Initial Date</th>
<th>Booster</th>
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<tbody>
<tr>
<td>Hepatitis A</td>
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<tr>
<td>Hepatitis B</td>
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<td>Human Papillomavirus Vaccine</td>
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<td>Meningococcal</td>
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<td>Polio</td>
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<td>Tetanus/Diphtheria/Pertussis</td>
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<td>Varicella</td>
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</tbody>
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Submit one or more of the following:

1) A healthcare provider's name, address, phone number and signature
2) A copy of a school or public health immunization record
3) A copy of a healthcare provider’s record.

*U.S. State license number of healthcare provider for TB tests done in foreign countries
HEALTH HISTORY FORM
This information is confidential and does not become part of your academic record.

Name ___________________________ UH ID # __________________

Date of Birth ______/_____/______ Gender: ❑ F ❑ M Phone # (_____) __________________ Area Code

Permanent Address ____________________________

Local Address ____________________________

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

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 UHHMS), hereby voluntarily and knowingly, authorize and give my express consent to the UHHMS 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 UHHMS staff.

SIGNATURE OF PARENT OR LEGAL GUARDIAN ____________________________ DATE ____________________________

In Case of Emergency, Notify:
Name ____________________________ Relationship ____________________________

Address ____________________________ Street ____________________________ City ____________________________ Phone (_____) ____________________________ Area Code ____________________________

State ____________________________ Zip Code ____________________________

Name, Address, & Phone # of Personal Physician:

Email ____________________________

Expected date of enrollment: ❑ Fall ❑ Spring ____________________________ Year

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 Sulfadiazine

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 8/2013