❑ **Fall 20 _____**

❑ **Spring 20_____**

❑ **Summer 20_____**

UNIVERSITY *of* HAWAI'I SYSTEM

Print Form

UH Hilo - **Student Medical Services**
Campus Center, Room 212.
200 W. Kāwili St. Hilo, HI 96720
Phone: (808) 932 7369 **Fax:** (808) 932-7368
Filedrop: hawaii.edu/filedrop/
Recipient:uhhsms@hawaii.edu

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
❑ Negative IGRA (QuantiFERON / T-SPOT) blood test

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, 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 ☐ MCV ❑ 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:_____

Save Form