

# HEALTH IMMUNIZATION CLEARANCE FORM

#### PRINT CLEARLY WITH DARK BLACK INK.



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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. 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 signed by a U.S. licensed medical practitioner.

JH Campus:	UH	UH ID:			Term:			
Student Name:		DOB:		Phone/Cell #:				
Are you an International Student: Yes	No	*Livin	ng on a UH c	ampus: `	es No			
This form has been completed to the best of mourposes of registration at the University of Ha		nd I freely co	onsent to th	is informa	ation being (	used for the	2	
Student Signature				I	Date (MM/DD	)/YYYY)		
Section A: IMMUNIZATIONS (To be completed by mmunizations shall include the complete date the minimum intervals between doses. For more info	ne vaccine was ac	dministered.	All immuniz				_	
MMR (Measles, Mumps, Rubella) 2 doses: 1s  Note: Mumps titers are NO longer accepted for proof of immu	st Dose unity. Month	Day	Year	2nd Dose	Month	Day	Year	
EXCEPTION: Check here if born before 1957	·	ŕ				,		
PRINT NAME OF LICENSED MEDICAL PRACTITIONER	SIGNATU	IRE OF LICENSE	D MEDICAL PRA	CTITIONER		DATE		
J.S. State & License Number	Healthca	re Facility						
TDaP (Tetanus-diphtheria-acellular pertussis) 1 dose:  Note: Valid TDaP dose must be administered on or after 1 rears of age. Do not confuse with DTaP (administered thildren 0-6 years of age). TDaP was licensed for use in the U. in 2005. Doses recorded as "TDaP" with an administration date in the U.S. prior to 2005 should not be counted.	<u>10</u> to S.	t <b>Dose:</b> Mor	nth Day	Year				
PRINT NAME OF LICENSED MEDICAL PRACTITIONER	SIGNATU	IRE OF LICENSE	D MEDICAL PRA	CTITIONER		DATE		
J.S. State & License Number	Healthca	re Facility						
/ARICELLA (Chicken Pox) 2 doses: 1s Note: Titers are NO longer accepted for proof of immunity.	st Dose:	Day	Year	2nd Dose:	Month	Day	Year	
EXCEPTION: Check here if born in the U.S. before	e 1980 Che	eck here if hist	tory of Varicell	a disease o	r Herpes Zoste	er (Mo/Year):		
PRINT NAME OF LICENSED MEDICAL PRACTITIONER	SIGNATU	IRE OF LICENSE	D MEDICAL PRA	CTITIONER		DATE		
LC State & License Number	Haalthaa	ro Facility						



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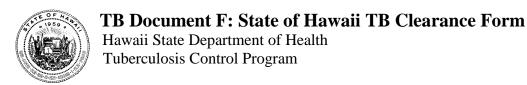
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# Section B: IMMUNIZATION FOR ON-CAMPUS HOUSING

*D	Alam in a state of the last and a second of	- + - 1: :		
*Required for new students to	the institution planning	g to live in on-campus noi	ising who are 21	years of age or younger.

	GOCOCCAL (MCV) (Tetanus-diphtheria-acellul	lar pertussis) 1 dose:	1st Dose:			
(At least	1 dose, on or after the age of 16 years.)		Mo	onth	Day \	/ear
PRINT NA	AME OF LICENSED MEDICAL PRACTITIONER	SIGNATURE OF LICE	NSED MEDICAL PRA	CTITIONER		DATE
U.S. State	e & License Number	Healthcare Facility				
The stu	n C: TUBERCULOSIS (TB) CLEARANCE (To be redeath has been evaluated using the process vidual does not have TB disease as defined in	s set out in the State	of Hawaiʻi DOH	TB Clear		nual and determined tha
Please o	complete <u>ONE</u> of the following:					
1)	State of Hawai'i Department of Health TB S (If completed and cleared, Form must be at		nent Clearance F	orm F (p	age 3 belo	ow).
	TB Screening Date:  Month Day Yea		gative TB risk ass	essment		
2)	PPD Skin Test:			Nega	tive Test f	or TB Infection
	Month Day (Note: The skin test must be read 48-72 hours aft		ation (mm) st be documented	in millimet	ers (mm).	
3)	Quantiferon Gold Test/Blood Test Result:	onth Day Year	Positive	Negativ	⁄e	
4)	Negative Chest X-Ray:  Month Day Yo	ear				
	clearance provides a reasonable assurance to timply any guarantee or protection from fu				isease at	the time of the exam. This
PRINT NA	ME OF LICENSED MEDICAL PRACTITIONER	SIGNATURE OF LICE	NSED MEDICAL PRA	CTITIONER		DATE
IIC Ctata	2. Licanca Number	Hoaltheara Facility				

DOH TB Control Program DOH TB Clearance Manual 7/18/2017



Patient Name	DOB	TB Screening Date

I have evaluated the individual named above using the process set out in the DOH TB Clearance Manual dated 2/10/17 and determined that the individual does not have TB disease as defined in section 11-164.2-2, Hawaii Administrative Rules.

2, Hawaii Administrative Rules.
Screening for schools, child care facilities or food handlers (TB Document A or E)
Negative TB risk assessment
☐ Negative test for TB infection
☐ Positive test for TB infection, and negative chest X-ray
Initial Screening for health care facilities or residential care settings (TB Document B or C)
☐ Negative test for TB infection (2-step)
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, negative CXR within previous 12 months,
and negative symptom screen
☐ Previous positive test for TB infection, and negative CXR
Annual Screening for Health care facilities or residential care settings (TB Document D)
☐ Negative test for TB infection
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, and negative symptoms screen
☐ Previous positive test for TB infection, and negative CXR
Signature or Unique Stamp of Practitioner:
Printed Name of Practitioner:
Healthcare Facility:

This TB clearance provides a reasonable assurance that the individual listed on this form was free from tuberculosis disease at the time of the exam. This form does not imply any guarantee or protection from future tuberculosis risk for the individual listed.