UNIVERSITY OF HAWAI'I • KAPI'OLANI COMMUNITY COLLEGE

Nursing Department
Nursing Student Health Checklist – Proof of Clinical Clearance

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<th>Name:</th>
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<th>First name &amp; Middle Initial</th>
<th>UH ID#:</th>
<th>E-mail Address:</th>
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**Nursing Program (Check One):**
- □ Associate Degree-Nursing
- □ LPN-RN Transition
- □ Practical Nursing
- □ Nurse Aide
- □ Surgical Technology

**Instructions:** Complete and submit all of the items listed below. All forms may be downloaded/printed from the KCC Website. Go to: Academics – Academic Programs – Nursing (find your specific program) – Toolbox – Health Requirements. **PLEASE RETURN THIS CHECKLIST FORM AND ALL REQUIRED HEALTH FORMS.** You may drop off forms in the Health Document mailbox located in the Kōpiko Building, Room 201 or mail to KCC Nursing Dept, 4303 Diamond Head Road, Honolulu, HI 96816, Attention: Kristy Yoshikawa.

**For Questions:** contact Kristy Yoshikawa at 808.734.9494 or nurshlth@hawaii.edu.

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| CPR certification: | Copy of Healthcare Provider level with AED certification – Be sure to copy both sides of your certification card.  
(Note: On-line certifications will NOT be accepted. Please check the Health Requirements webpage for other restrictions.) |
| FIRST AID certification: | Copy of Basic First Aid certification – Be sure to copy both sides of your certification card.  
*(For NURSE AIDE Program and SURGICAL TECHNOLOGY Program only)* |
| TUBERCULOSIS (TB) - ONE of the following: | Copies of a current two-step TB skin test (2 separate injections) with negative results - all indurations must be reported even if the reading is negative (0mm – 9mm) OR  
Copies of a single negative TB skin test (in the current year) and a two-step TB test within the last 365 days prior OR  
Copies of a past history of a two-step TB skin test with two consecutive years of a negative TB skin tests (e.g., current TB skin test with another TB skin test completed within 365 days prior).  
If you’ve had a positive skin test, provide the date with induration size (i.e. 10mm or more) AND a current negative Chest x-ray result. Please be aware that you may be required to submit updated current chest x-ray and waiver form if required by a clinical agency. You must also complete the Hawaii Pacific Health (HPH) TB Questionnaire and Tripler Army Medical Center (TAMC) TB Risk Assessment Tool (signed by your healthcare provider) and the KCC chest x-ray waiver forms.  
*(Tdap) TETANUS, DIPHTHERIA and PERTUSSIS: (not applicable for NURSE AIDE Program)*  
Copy of proof of Tdap vaccination for tetanus, diphtheria and pertussis (within 10 years). |
| RUBELLA: | Copy of proof of Rubella titer blood test. (If tested negative, please contact Ms. Yoshikawa for further instructions.)  
*(not applicable for NURSE AIDE Program)* |
| RUBEOLA (Measles): | Copy of a positive Measles titer blood test. (If tested negative, please contact Ms. Yoshikawa for further instructions.)  
*(not applicable for NURSE AIDE Program)* |
| VARICELLA (Chicken pox): | Copy of a positive Varicella (chicken pox) titer blood test. (If tested negative, please contact Ms. Yoshikawa for further instructions.)  
*(not applicable for NURSE AIDE Program)* |
| MUMPS: | Copy of a positive Mumps titer blood test. (If tested negative, please contact Ms. Yoshikawa for further instructions.)  
*(not applicable for NURSE AIDE Program)* |
| HEPATITIS B Immunity: | Copy of a positive Hepatitis B titer blood test (HbsAb). (Nurse Aide applicants only require a copy of the 3 Hepatitis immunizations.) (If tested Negative, please contact Ms. Yoshikawa for further instructions.) |
| INFLUENZA VACCINATION Current Seasonal Documentation: | Copy of proof of vaccination within the current seasonal period.  
*(not applicable for NURSE AIDE Program)* |
| INFLUENZA VACCINE Attestation/Declaration Forms: |  
*KCC Influenza Vaccination Attestation/Declaration Form* - Original, signed and dated. The only reason to decline the flu vaccine must be substantiated by a medical note from your primary care provider.  
*HPH Non-Employee Inactivated Non-Employee Influenza Vaccine Declaration Form* - Original, signed and dated. |
| PHYSICAL EXAMINATION FORM: | Original form, completed by your PCP, of a current physical examination, verifying ability to perform program activities. |
| MEDICAL CONSENT FORM: | Original, signed and dated |
| UNDERSTANDING AND AGREEMENT FORM: | Original, signed and dated |
| EXCLUSION OF WORKERS’ COMPENSATION/CONFIRMATION OF HEALTH INSURANCE COVERAGE FORM: | Original, signed and dated; AND COPY OF VALID INSURANCE CARD (front and back). |
| DOCUMENT RELEASE FORM: | Original, signed and dated |
| HEALTH REQUIREMENT SUBMISSION AGREEMENT FORM: | Original, signed and dated |

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