



## HEALTH CLEARANCE FORM

All students must meet State of Hawaii Department of Health (DOH) Health Clearance requirements (Hawaii Administrative Rules, Title 11-157). Registration will not be allowed until all health clearances are met and submitted to Admissions in 'Ilima 102. These health clearances must be completed and signed by a U.S. licensed healthcare provider (M.D, D.O., A.P.R.N., P.A.).

Name: \_\_\_\_\_

UH ID: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### TUBERCULOSIS (TB) CLEARANCE

- TB clearance must be dated within one year of the first day of the semester. Transfer or returning students who are/were enrolled at a Hawai'i college may submit a copy of the original clearance certificate used to first attend a post-secondary school in Hawai'i.
- Please complete the TB Risk Assessment Form (TB Document G) and have your U.S. licensed healthcare provider review your completed form, mark the appropriate box and sign this section.

#### **For Physician or Clinic Use Only:**

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, Hawai'i Administrative Rules. This TB clearance provides 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 TB risk for the individual listed.

Negative TB Risk Assessment & Symptom Screen. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Negative TB Test or IGRA (QFT). Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Negative CXR. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name Physician/Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Official Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION**

- A student born before 1957 is exempt from the MMR immunization requirement.
- Proof of two doses of the Measles (Rubeola) vaccine, at least ONE must be the MMR vaccine with the first does on or after 12 months of age, and the second dose at least 4 weeks after the first dose; OR
- Positive MMR IgG blood test report.

#### COMPLETE ONE OF THE FOLLOWING:

1. MMR Date 1) \_\_\_\_/\_\_\_\_/\_\_\_\_

MMR Date 2) \_\_\_\_/\_\_\_\_/\_\_\_\_

OR

2. Measles (Rubeola) Vaccine Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Mumps Vaccine Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Rubella Vaccine Date \_\_\_\_/\_\_\_\_/\_\_\_\_

OR

3. Submit MMR IgG blood test report

Printed Name Physician/Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Official Signature: \_\_\_\_\_ Date: \_\_\_\_\_