

- Fall 20 _____
- Spring 20 _____
- Summer 20 _____



UNIVERSITY of HAWAII
SYSTEM

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

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       GOAMEDI     SOAHOLD     OnBase