Dear Entering Student:

Welcome to University of Hawai’i Maui College! The Campus Health Center (CHC) is located on campus near the Veteran’s office and Hawaiian Services Building. A professional staff of APRN’s and nurses provide for the health needs of the students. CHC has a general medical clinic for ambulatory care and specialty clinics by appointment. We assist with TB and immunization requirements as required by Hawaii law. Please visit our web site at http://maui.hawaii.edu/health-center/

HEALTH CLEARANCE REQUIREMENTS (Hawai’i Administrative Rules, DOH Title 11, Chapter 157) The State of Hawai’i mandates that certain health requirements be met for entrance to post-secondary educational institutions. All students, including faculty/staff enrolled as students, must comply with health clearance requirements by completing the Health Clearance Form and Immunization Record and returning it by mail, fax or secure email to the Health Services. Please follow instructions for Tuberculosis Clearance and Immunization Requirements carefully. Observe the deadline - You may not attend classes until you have received health clearance.

1) TUBERCULOSIS (TB) CLEARANCE (Effective March 17, 2018)

U.S. Students: Complete the TB Risk Assessment Form and have your U.S. licensed healthcare provider (M.D., D.O., A.P.R.N., or P.A.) sign your completed form. A TB clearance needs to be obtained within twelve months prior to your start date or obtained on or after age sixteen. If your TB Risk Assessment is positive, a TB skin test, IGRA or CXR is required. Students with history of a positive PPD and negative chest x-ray must complete and return the Tuberculosis Symptom Screening form. This form can be found on our website: http://maui.hawaii.edu/health-center/

Students Coming from Foreign Countries:

The TB Risk Assessment Form must be completed and signed by a U.S. licensed healthcare provider (M.D., D.O., A.P.R.N., or P.A.). The U.S. licensed healthcare practitioner must document the state he/she is licensed and license number. The TB Risk Assessment Form may be completed upon arrival in Kahului, at our Campus Health Center, the Hawai’i State Department of Health, or a private physician’s office. If your TB Risk Assessment is positive, a TB skin test, IGRA or CXR is required.

Positive TB Risk Assessment Students:

If you have recently taken the MMR or Varicella vaccine (or any live vaccine), you must wait 4 weeks to take the TB skin test or TB blood test. A chest x-ray can be done to preliminarily complete the tuberculin requirement. The chest x-ray will allow you to register, however you are still required to have the TB skin test or blood test done 4 weeks after your MMR vaccine.

2) MEASLES, MUMPS, AND RUBELLA (MMR), Tetanus-diptheria-pertussis (Tdap), Varicella, Meningococcal Conjugate (MCV)* IMMUNIZATIONS

Two doses of MMR vaccines are required. First dose must have been given on or after 12 months of age and the second must have been given at least 4 weeks after the first dose. No doses administered prior to 1968 are acceptable. Measles, Mumps and Rubella immunizations may be waived if: 1) Student was born before 1957,

Two doses of varicella (chickenpox) are required. The first dose must be given on or after 12 months of age and the second dose given at least 4 weeks after the first dose. The varicella immunization may be waived if the student provides laboratory evidence of positive antibodies to varicella (chickenpox), was born in the United States before 1980, has a documented history of the disease signed by an MD, D), NP or PA.

One dose of Tdap (tetanus-diphtheria-pertussis) administered within the last 10 years after age 11.

Meningococcal Conjugate (MCV)* First-year students living in on-campus housing only
HEALTH CLEARANCE FORM

**Student Instructions:**
1) Complete box 1 by filling in your personal information. Please sign in box 1.a.
   Only complete box 1.b. if you plan to receive health care services from one of our University Health Centers (at UH Manoa, UH Hilo, Leeward CC or Maui College).
2) Information in boxes 2, 3, & 4 must be completed by a U.S. licensed medical provider [Physician, advanced practice registered nurse (APRN), or physician assistant (PA)].
3) Health clearances must be submitted as soon as possible, failure to do so may result in disenrollment.
4) By filling out this form, you authorize the Health Clearance form to be sent to the University of Hawai‘i system and to be shared within the University of Hawai‘i system.

**Medical Provider Instructions:**
1) Complete boxes 2, 3, & 4. Be sure to sign and stamp each section you complete.

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**Box 1: STUDENT INFORMATION**

Name ____________________________________________________________

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
</tr>
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UH Number or Username ________________________________ Email Address ____________________________

Daytime Phone ____________________________ Birth Date ____/_____/______ Born in the U.S.: Yes____ No____

Taking courses on campus: Yes____ No____ Select term attending: FALL 20_______ SPRING 20_______ SUMMER 20_______

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**Box 1.a: PERSONAL HEALTH CLEARANCE INFORMATION** – 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. To comply with DOH 11-157.6.4: School, post-secondary school, and child care facility reporting and records (b) School, post-secondary school, and childcare facility records documenting compliance with this chapter shall be made available for inspection and copying by the department upon request.

_________________________________________________________
SIGNATURE OF STUDENT (Parental signature required if under 18) DATE

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**Box 1.b:** Please complete the following section ONLY IF you (student) will be selecting to receive healthcare services from an on campus health facility.

**Authorization and Consent for Treatment of Minors:**
To be completed by Parent or Guardian if the student will be 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 Maui College Health Center, hereby voluntarily and knowingly, authorize and give my express consent to the UH Maui College 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 UH Maui College Health Center staff.

_________________________________________________________
SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

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To send electronically File Drop to: www.hawaii.edu/filedrop Intended Recipient: healthct@hawaii.edu
VACCINATION REQUIREMENTS: (U.S. Licensed Medical Provider’s Use Only)

Medical Provider must sign at the bottom. All immunizations must meet minimum ages and minimum intervals between doses.

Required Immunizations for all students:
- Measles, Mumps, Rubella (MMR) - 2 doses
- Tetanus-Diphtheria-Pertussis (Tdap) - 1 dose
- Varicella - 2 doses

Required Immunization for first year students 21 years of age and younger, living in on-campus housing:
- Meningococcal Conjugate (MCV): at least 1 dose, on or after the age of 16 years

Exceptions to Immunization Requirements:
- Students born prior to 1957 are exempt from the MMR vaccination requirement
- Students born in the United States prior to 1980 are exempt from the Varicella vaccination requirement
- Students with documented history of Varicella disease, signed by a US licensed physician, nurse practitioner or physician assistant, may be substituted for a record of Varicella vaccination

Box 3: IMMUNIZATION DATES:

1) 2-MMR (Measles, Mumps, Rubella) Date 1) ___/___/____ 2) ___/___/____
2) 2-Varicella Date 1) ___/___/____ 2) ___/___/____
3) 1-Tdap (Tetanus-diphtheria-pertussis) Date 1) ___/___/____

Box 4: STUDENT HOUSING INFORMATION (Only complete if the student will be living in on-campus housing.)

- Residing in on-campus dorms: Yes _____ No _____
- First year student 21 years of age and younger: Yes _____ No _____
- If yes to both, please provide MCV immunization date: Date: ___/___/____

This form may be rejected if it is not fully completed and signed in both sections by licensed medical provider in the United States. Revised 11/05/19 UHSYS-SA