University of Hawai'i Maui College - Campus Health Center FALL 20 _____ SPRING 20 _____ SUMMER 20_____
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UNIVERSITY OF HAWAI'I MAUI COLLEGE – HEALTH CLEARANCE FORM

Student Instructions:
1) Complete box 1 by filling in your personal information.
2) Information in boxes 2 & 3 must be completed by a **physician/clinic** in the United States .
3) Health clearances must be submitted before registration for ALL new, transfer and returning students or registration will not be allowed.
4) By filling out this form, you authorize TB test results/required vaccination information to be sent to the University of Hawaii college system.

Physician/Clinic Instructions: 1) Complete boxes 2 & 3. Be sure to sign and stamp each section you complete.

Box 1: STUDENT INFORMATION

Name _____ UH Number or Username _____
Last Name *First Name* *M.I.*

Mailing Address_____ City_____ State _____ Zip _____

Email Address_____ Daytime Phone _____ Birthdate ____/____/____

TUBERCULOSIS CLEARANCE REQUIREMENTS

- TB clearance must be dated *within **one year** of the first day of the semester* by a US licensed Healthcare provider (MD, DO, APRN, or PA). Skin test must be **read within 48-72** hours administration and documented in mm. If positive, a chest X-ray is required.
- TB test & chest x-rays must be done in the continental U.S., Alaska, Hawai'I or a U.S. military base. Tests or x-rays done anywhere else **will not be accepted. Quantiferon is accepted as a test for Tuberculosis in the State of Hawaii.**

Box 2: Physician's/Clinic's Use Only: *Please check screening form on back

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 meets State of Hawaii criteria for TB Clearance as defined in section 11-164.2-2, Hawaii Administrative Rules.

Signature or Unique Stamp of Practitioner: _____

Printed Name of Practitioner: _____Date: _____

Healthcare Facility: _____

Note: 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.

MEASLES MUMPS RUBELLA (MMR) CLEARANCE REQUIREMENTS (One of the following):

- Proof of **one** dose of the Measles (Rubeola) vaccine, and **one** dose of Measles/Mumps/Rubella (MMR) vaccine, ***OR***
- Proof of **two** doses of the Measles/Mumps/Rubella (MMR) vaccinations, ***OR***
- Positive Measles Mumps Rubella (MMR) IgG blood test report if student had diseases, or if vaccines were administered, but no record is available (Physician in the United States must review and sign report below),***OR***
- Student was born before 1957.

Note: Vaccines should be one month apart, given on or after January 1, 1968; **and/or after the student's first birthday.**

Box 3: Physician's/Clinic's Use Only:	**DATE OF IMMUNIZATION**	
VACCINE	**#1**	**#2**
Measles *OR*	____/____/____	**MMR Required**
Mumps Measles Rubella (MMR)	____/____/____	____/____/____

TITER TEST
Attach signed (by the MD or RN) photocopy of the Positive IgG Blood Test Results for Measles, Mumps, Rubella (MMR).

Printed Name & Title _____ Date _____ Telephone No. _____

MD, APRN or RN Signature _____ Official Stamp _____
UH Number: _____ ☐ SOAHOLD ☐ GOAMEDI MR _____ TB _____ By/Date: _____

This form may be rejected if it is not fully completed and signed in both sections by an MD, DO, APRN, or PA. in the United States (other than your spouse, parent, or self). If a copy of TB Card or lab report is attached, then no signature is required.

1. Check for TB symptoms

- If there are significant TB symptoms, then further testing (including a chest x-ray) is required for TB clearance
- If Significant symptoms are absent, proceed to TB Risk Factor questions.

☐ Yes ☐ No	**Does this person have significant TB symptoms?** Significant symptoms include <u>cough for 3 weeks or more</u>, plus at least one of the following: ☐ Coughing up blood ☐ Fever ☐ Night sweats ☐ Unexplained weight loss ☐ Unusual weakness ☐ Fatigue

2. Check for TB Risk Factors

☐ Yes ☐ No	**Was This person born in the country with an elevated TB rate?** Includes countries other than the United States, Canada, Australia, New Zealand, or Western and Northern European countries.
☐ Yes ☐ No	**Has this person traveled to (or lived in) a country with an elevated TB rate for four weeks or longer?**
☐ Yes ☐ No	**At any time has this person been in contact with someone with *infectious* TB *disease*?** **(Do not check "yes" if exposed only to someone with latent TB)**
☐ Yes ☐ No	**Does the individual have a health problem that affects the immune system, or is medical treatment planned that may affect the immune system?** *(Includes HIV/AIDS, organ transplant recipient, treatment with TNF-alpha antagonist, or steroid medication for a month or longer)*
☐ Yes ☐ No	**For persons under age 16 only: Is someone in the child's household from a country with an elevated TB rate?**

- If any "Yes" box in section 2 is checked, then TB testing is required for TB clearance
- If all boxes in section 2 are checked "No", then TB clearance can be issued without testing

TB (PPD-Mantoux) Date given: _____ Date read: _____ Results (in mm): _____

<u>OR</u>

CHEST X-RAY (if skin test is positive) Date x-ray taken: _____ Results: _____

MD or RN Signature _____ Official Stamp _____

Printed Name and Title _____ Date _____ Telephone No. _____

Provider Name with Licensure/Degree: **Assessment Date:**	**Person's Name and DOB:** **Name and Relationship of Person Providing Information (if not the above named person):**