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FALL 20 _____ SPRING 20 _____ SUMMER 20_____

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

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.

Screening for post-secondary schools (*TB Document A or E*)

- □ **Negative TB risk assessment**
- □ **Negative test for TB infection**
- □ **Positive test for TB infection, and negative chest X-ray**

Signature or Unique Stamp of Practitioner: _____

Printed Name of Practitioner: _____

Healthcare Facility: _____

Date: _____

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.

Rev dlc 04/19//18

FOR ALL NEW STUDENTS: Complete this TB Risk Assessment (circle Yes or No) and have your US Licensed Healthcare Provider sign completed form.
FOR RETURNING or TRANSFERRING STUDENTS: Submit a copy of the TB certificate done on or after age 16.

Yes* No	1. Do you have a cough that has lasted for 3 weeks or longer?
Yes* No	2. What country were you born in? List Country:
Yes* No	3. Have you lived in or traveled to (for 4 or more weeks) a country **other than** the United States? List country:
Yes* No	4. At any time, have you been around someone who was sick with *TB disease*? Do not circle "Yes" if exposed only to someone with a positive TB skin test (latent TB infection)
Yes* No	5. Do you have a health problem or do you plan to be on medical treatment that may affect the immune system? Includes HIV/AIDS, organ transplant, treatment with TNF-alpha antagonist (ex: Humira, Enbrel, Remicade) or steroid medication for a month or longer.

IF THE ANSWER TO ALL OF THE ABOVE QUESTIONS IS NO, HAVE YOUR U.S. LICENSED HEALTHCARE PROVIDER SIGN FORM. GO ON TO PART II REQUIRED MEASLES (RUBEOLA), MUMPS, AND RUBELLA (GERMAN MEASLES) OR MMR.

***IF THE ANSWER IS YES TO ANY OF THE ABOVE QUESTIONS THE FOLLOWING IS REQUIRED:**

- Have a Tuberculin skin test (TST) **OR** Tuberculosis blood test (QFT, T-Spot) done:
  - Testing must be done by a U.S. licensed healthcare provider (M.D., D.O., N.D., A.P.R.N., or P.A.) and within ONE year prior to initial attendance.
  - The TST interpretation should be based on mm of induration as well as risk factors. **Negative and 4 days readings are NOT accepted.** A **positive** TB skin test requires a chest x-ray. A **positive or borderline** IGRA test requires a chest x-ray.
  - If the test was done in a foreign country, a U.S. licensed healthcare provider must document the U.S. state and number in which they are licensed AND the TB test solution used must be FDA approved, either Tubersol or Aplisol
- **UPON COMPLETION OF PART 1, have your US Licensed Healthcare Provider sign form and GO ON TO PART II: REQUIRED: MEASLES (RUBEOLA), MUMPS, AND RUBELLA (GERMAN MEASLES).**

TB (PPD-Mantoux) □ Tubersol or □Aplisol Date given: _____ Date read: _____ Results (in mm): ____

IGRA: □QFT or □T-Spot Date: _____ **Result** (circle one): Negative Positive Borderline Indeterminate/Invalid

CHEST X-RAY (if TST or IGRA is positive) Date x-ray taken: _____ Results: _____

_____

Name of Physician/Healthcare Provider U.S. State & license number (*TB done in Foreign Country) Signature Date

_____

Address City State Zip Code