HEALTH CLEARANCE REQUIREMENT

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 postsecondary educational institutions. All 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 HELP.

1) TUBERCULOSIS (TB) CLEARANCE (REQUIRED)

A TB Clearance needs to be obtained within twelve months prior to your start date or obtained on or after age sixteen. International Students may submit a IGRA or Quantiferon blood test or complete a TB skin test. If test is positive, a chest x-ray is required. Students who study for longer than 6 months in Hawaii will be required to take another TB test in the U.S. The U.S. TB test can be done in Hawaii at no cost.

2) IMMUNIZATION CLEARANCE (REQUIRED)

MEASLES, MUMPS, AND RUBELLA (MMR) VACCINES: Two MMR vaccines are required.

- If you are born before 1957, you are exempt from the MMR requirements.
- Titers are no longer acceptable.

TDAP (TETANUS, DIPHTHERIA, ACELLULAR PERTUSSIS) VACCINE:

- Must be administered on or after age 11.

VARICELLA (CHICKEN POX) VACCINE: Two Varicella vaccines are required.

- If you had Varicella disease or infection, your Healthcare Provider must document date of disease or infection and sign.
- If you were born in the U.S. before 1980 you are exempt from the Varicella requirements.

Please complete the Health Clearance Form (back side). You need to take this form to your physician and get a verification of your immunizations OR obtain the necessary immunizations. Your physician's signature is required on the form. It is recommended that you have a U.S. Licensed Healthcare provider complete the form. If you are unable to consult a U.S. Licensed Healthcare provider, we will review your records to determine if they are satisfactory.

Please keep in mind that you must submit Health Clearance Form with your HELP application. You will not be able to attend our program without completing this form. All the information you provide will be treated confidentially and will not become a part of your academic records.

1890 East-West Road, Moore Hall 586, Honolulu, HI, 96822
Telephone: (808) 956-6636
Web: http://manoa.hawaii.edu/eslhelp

HEALTH CLEARANCE FORM

NAME: _____ BIRTHDATE: _____

TUBERCULOSIS (TB) CLEARANCE

A Tuberculin skin test (PPD – Mantoux) within one year prior to enrollment is required. Skin test results must be read in 48 to 72 hours. If positive, a chest x-ray is required. **If you attend more than six months in our program, you will be required to take an additional TB test in the State of Hawaii.*

SKIN TEST (PPD – Mantoux)
Date Given: _____/_____/_____
RESULTS: Positive ☐ Negative ☐
(Please indicate the size of reaction, in mm)

CHEST X-RAY (if skin test is positive)
Date Given: _____/_____/_____
RESULTS:
☐ Revealed no abnormalities
☐ Others (Explain) _____

IMMUNIZATIONS

1. MEASLES, MUMPS, RUBELLA (MMR)

TWO(2) doses of the MMR (Measles, Mumps, and Rubella) immunization are required. If the student received 2 MMR doses, please fill out the date of immunizations in (a). If the student received separate doses of the measles, mumps, and rubella immunizations, please use (b). MMR immunization may be waived if the student was born before 1957.

a. Proof of two MMR immunizations:
First Dose: _____/_____/_____ *MONTH/DAY/YEAR* Second Dose: _____/_____/_____ *MONTH/DAY/YEAR*

b. Measles (Rubeola) vaccine: 1) _____/_____/_____ 2) _____/_____/_____
Mumps vaccine: 1) _____/_____/_____ 2) _____/_____/_____
Rubella vaccine: 1) _____/_____/_____ 2) _____/_____/_____
MONTH/DAY/YEAR *MONTH/DAY/YEAR*

2. TDAP (TETANUS-DIPHTHERIA-ACELLULAR PERTUSSIS) 1 dose:

Date of immunization (on or after age 11): _____/_____/_____
MONTH/DAY/YEAR

3. VARICELLA (CHICKENPOX):

TWO(2) doses of the Varicella (chickenpox) immunization are required. If student has record of infection, indicate the date of infection. Varicella immunization may be waived if the student was born before 1980.

a. Proof of two Varicella (chickenpox) immunizations:
First Dose: _____/_____/_____ *MONTH/DAY/YEAR* Second Dose: _____/_____/_____ *MONTH/DAY/YEAR*

b. History of Varicella disease (if applicable): Date of infection: _____/_____/_____
MONTH/DAY/YEAR

***Does the Student have any significant medical conditions or disabilities that would limit participation in academic and/or physical activities? (Specify)** _____
*** Any other comments on the Student's Health:** _____

Signature of the Physician: _____ **Date:** _____

_____
Name of Physician and/or Clinic/Hospital Telephone Number

_____
Address City State Zip Country

UNIVERSITY OF HAWAI'I AT MĀNOA HELP HAWAI'I ENGLISH LANGUAGE PROGRAM

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