FALL 20____
SPRING 20____
SUMMER 20____

University of Hawai'i - Leeward Community College
Student Health Center
96-045 Ala 'Ike · Pearl City, HI 96782-3393
Phone: 808.455.0515 · Fax: 808.455.0267
www.hawaii.edu/shs/lcc

HEALTH CLEARANCE FORM

Instructions:

1. Please complete the sections below and return this form to the Health Center, AD-122. Please note that registration will not be allowed until all health clearances are met.
2. These health clearances must be completed by a U.S. licensed MD, DO, APRN, PA or clinic.

Name____ __ UH ID ________________________
Last First Middle

Mailing Address______________________________________ City ___________ State ____ Zip code _________

Email Address __________________________________ Daytime Phone ____________ Birthdate ___ /___ /___

TUBERCULOSIS CLEARANCE REQUIREMENTS

- TB clearance must be dated within one year of the first day of the semester and clearly state that the skin test or chest x-ray was negative. Transfer or returning students who are/were enrolled at a Hawai'i college may bring a copy of the original clearance certificate used to first attend a post-secondary school in Hawai'i.

For Physician's/Clinic Use Only:

TB (PPD-MANTOUX) Date given: _______________ Date read: _______________ Results (in mm): ___________

OR

CHEST X-RAY (required if skin test is positive, 10mm or >) Date x-ray taken: ____________ X-ray results: ________________________

Printed Name of Physician/Clinic ____Telephone No. ________________________

Official Signature ____ Date ________________

MEASLES, MUMPS, RUBELLA (MMR) CLEARANCE REQUIREMENTS

- A student born before 1957 is exempt from the Measles, Mumps, and Rubella immunization requirement
- Proof of TWO doses of the Measles (Rubeola) vaccine, at least ONE must be the Measles, Mumps, Rubella (MMR) vaccine with the first dose on or after 12 months of age and second dose at least 4 weeks after the first dose ,OR
- Positive Measles, Mumps, Rubella (MMR) lgG blood test report (copy of blood test report required)

COMPLETE ONE OF THE FOLLOWING:

1. Proof of two MMR immunizations: Date 1) ________________________ (mo) (day) (year) 2) ___________________________ (mo) (day) (year)

2. Measles (Rubeola) vaccine 1) _____ /_____ 2) _____ /_____ or Physician documentation of disease: date __________
   Mumps vaccine 1) _____ /_____ or Physician documentation of disease: date __________
   Rubella vaccine 1) _____ /_____ or Physician documentation of disease: date __________

3. Antibody titers: **Measles**: Date _____________ titer results _______________
   Mumps: Date _______________ titer results ______________ **Rubella**: Date ______________ titer results ___________

Printed Name of Physician/Clinic _______________________________________ Phone No. ___________________________

Signature ____ Date _______________________________

OFFICE USE ONLY

□ TB □ MMR □ SOAHOLD □ GOAMEDI

By/Date: _______________