HEALTH IMMUNIZATION CLEARANCE FORM

PRINT CLEARLY WITH DARK BLACK INK.
This form will be read by a computer.
Upload to medproctor.com

The State of Hawaiʻi Department of Health (DOH) Hawaiʻi Administrative Rules, Title 11 (Chapter 157 and 164.2) requires certain health requirements be met for attendance to a post-secondary institution. Health clearances must bear the signature of the practitioner, stamp, or imprinted name of the department or practitioner or name of licensed facility. A practitioner is a physician, advanced practice registered nurse (APRN), or physician assistant (PA) licensed to practice in the United States. *This form may be rejected if it is not signed by a U.S. licensed medical practitioner.*

UH Campus: UH ID: Term:

Student Name: DOB: Phone/Cell #:

Are you an International Student: Yes No *Living on a UH campus: Yes No

This form has been completed to the best of my knowledge, and I freely consent to this information being used for the purposes of registration at the University of Hawaiʻi.

Student Signature Date (MM/DD/YYYY)

Section A: IMMUNIZATIONS *(To be completed by U.S. licensed medical practitioner.)*

Immunizations shall include the complete date the vaccine was administered. All immunizations must meet the minimum ages and minimum intervals between doses. For more information on Religious or a Medical Exemption visit: https://www.hawaii.edu/health-clearance/.

MMR (Measles, Mumps, Rubella) 2 doses: 1st Dose Month Day Year 2nd Dose Month Day Year
*Note: Mumps titers are NO longer accepted for proof of immunity.

EXCEPTION: Check here if born before 1957

PRINT NAME OF LICENSED MEDICAL PRACTITIONER SIGNATURE OF LICENSED MEDICAL PRACTITIONER DATE

U.S. State & License Number Healthcare Facility

TDaP (Tetanus-diphtheria-acellular pertussis) 1 dose: 1st Dose: Month Day Year

Note: Valid TDaP dose must be administered on or after 10 years of age. Do not confuse with DTaP (administered to children 0-6 years of age). TDaP was licensed for use in the U.S. in 2005. Doses recorded as "TDaP"with an administration date in the U.S. prior to 2005 should not be counted.

PRINT NAME OF LICENSED MEDICAL PRACTITIONER SIGNATURE OF LICENSED MEDICAL PRACTITIONER DATE

U.S. State & License Number Healthcare Facility

VARICELLA (Chicken Pox) 2 doses: 1st Dose: Month Day Year 2nd Dose: Month Day Year
*Note: Titers are NO longer accepted for proof of immunity.

EXCEPTION: Check here if born in the U.S. before 1980 Check here if history of Varicella disease or Herpes Zoster (Mo/Year):

PRINT NAME OF LICENSED MEDICAL PRACTITIONER SIGNATURE OF LICENSED MEDICAL PRACTITIONER DATE

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Section B: IMMUNIZATION FOR ON-CAMPUS HOUSING

*Required for new students to the institution planning to live in on-campus housing who are 21 years of age or younger.

MENINGOCOCCAL (MCV) (Tetanus-diphtheria-acellular pertussis) 1 dose: 1st Dose:
(At least 1 dose, on or after the age of 16 years.) Month Day Year

PRINT NAME OF LICENSED MEDICAL PRACTITIONER SIGNATURE OF LICENSED MEDICAL PRACTITIONER DATE

U.S. State & License Number Healthcare Facility

Section C: TUBERCULOSIS (TB) CLEARANCE *(To be completed by U.S. licensed medical practitioner.)*

The student has been evaluated using the process set out in the State of Hawaiʻi DOH TB Clearance Manual and determined that the individual does not have TB disease as defined in section 11-164.2-2, Hawai`i Administrative Rules.

Please complete ONE of the following:

1) State of Hawaiʻi Department of Health TB Screening/Risk Assessment Clearance Form F (page 3 below).
(If completed and cleared, Form must be attached)

TB Screening Date: Month Day Year NNegative TB risk assessment

2) PPD Skin Test: Month Day Year Induration (mm) Negative Test for TB Infection
(Note: The skin test must be read 48-72 hours after administration and must be documented in millimeters (mm).

3) Quantiferon Gold Test/Blood Test Result: Month Day Year Positive Negative

4) Negative Chest X-Ray: Month Day Year

This TB clearance provides a reasonable assurance that the individual was free from tuberculosis disease at the time of the exam. This does not imply any guarantee or protection from future tuberculosis risk for the individual listed.

PRINT NAME OF LICENSED MEDICAL PRACTITIONER SIGNATURE OF LICENSED MEDICAL PRACTITIONER DATE

U.S. State & License Number Healthcare Facility

TB Document F: State of Hawaii TB Clearance Form

Hawaii State Department of Health
Tuberculosis Control Program

Patient Name	DOB	TB Screening Date

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 does not have TB disease as defined in section 11-164.2-2, Hawaii Administrative Rules.

Screening for schools, child care facilities or food handlers *(TB Document A or E)*
☐ Negative TB risk assessment
☐ Negative test for TB infection
☐ Positive test for TB infection, and negative chest X-ray

Initial Screening for health care facilities or residential care settings (*TB Document B or C)*
☐ Negative test for TB infection (2-step)
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, negative CXR within previous 12 months, and negative symptom screen
☐ Previous positive test for TB infection, and negative CXR

Annual Screening for Health care facilities or residential care settings (*TB Document D)*
☐ Negative test for TB infection
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, and negative symptoms screen
☐ Previous positive test for TB infection, and negative CXR

Signature or Unique Stamp of Practitioner: ______________________________________

Printed Name of Practitioner: ______________________________________

Healthcare Facility: ______________________________________

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.

TB Document G: State of Hawaii TB Risk Assessment for Adults and Children

Hawaii State Department of Health
Tuberculosis Control Program

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 cough for 3 weeks or more, 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

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

☐ Yes ☐ No	**Was this person born in a country with an elevated TB rate?** Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North 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?**

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

ここのページから
日本語説明とサンプルです。

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HEALTH IMMUNIZATION CLEARANCE FORM

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↓LCCを選ぶ ↓Acceptance letterに記載 ↓入学時期

UH Campus: Leeward Community College UH ID: 34569876 Term: Fall

↓生年月日

Student Name: Yoshio Tanaka DOB: 10/29/1999 Phone/Cell #: 8081234567

氏名↑ ↑電話番号

Are you an International Student: ☑ Yes ☐ No *Living on a UH campus: Yes ☐ No ☑

↑チェック ↑チェック

This form has been completed to the best of my knowledge, and I freely consent to this information being used for the purposes of registration at the University of Hawai'i.

本日の日付↓

Student Signature 田中よしお Date (MM/DD/YYYY) 2/28/23

↑サインする

Section A: IMMUNIZATIONS *(To be completed by U.S. licensed medical practitioner.)* ↓ここからはアメリカの医師免許保持の医師が記載

Immunizations shall include the complete date the vaccine was administered. All immunizations must meet the minimum ages and minimum intervals between doses. For more information on Religious or a Medical Exemption visit: https://www.hawaii.edu/health-clearance/.

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*Note: Mumps titers are NO longer accepted for proof of immunity.

EXCEPTION: ☐ Check here if born before 1957

PRINT NAME OF LICENSED MEDICAL PRACTITIONER ______ SIGNATURE OF LICENSED MEDICAL PRACTITIONER ______ DATE ______

U.S. State & License Number ______ Healthcare Facility ______

TDaP (Tetanus-diphtheria-acellular pertussis) 1 dose: 1st Dose: ______ (Month Day Year)

Note: Valid TDaP dose must be administered on or after 10 years of age. Do not confuse with DTaP (administered to children 0-6 years of age). TDaP was licensed for use in the U.S. in 2005. Doses recorded as "TDaP"with an administration date in the U.S. prior to 2005 should not be counted.

PRINT NAME OF LICENSED MEDICAL PRACTITIONER ______ SIGNATURE OF LICENSED MEDICAL PRACTITIONER ______ DATE ______

U.S. State & License Number ______ Healthcare Facility ______

VARICELLA (Chicken Pox) 2 doses: 1st Dose: ______ (Month Day Year) 2nd Dose: ______ (Month Day Year)
*Note: Titers are NO longer accepted for proof of immunity.

EXCEPTION: ☐ Check here if born in the U.S. before 1980 ☐ Check here if history of Varicella disease or Herpes Zoster (Mo/Year): ______

PRINT NAME OF LICENSED MEDICAL PRACTITIONER ______ SIGNATURE OF LICENSED MEDICAL PRACTITIONER ______ DATE ______

U.S. State & License Number ______ Healthcare Facility ______

Sample!!!

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UNIVERSITY of HAWAIʻI SYSTEM

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Section B: IMMUNIZATION FOR ON-CAMPUS HOUSING LCCは学生寮がないのでここの部分は不要

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MENINGOCOCCAL (MCV) (Tetanus-diphtheria-acellular pertussis) 1 dose: 1st Dose: ____________ Month Day Year
(At least 1 dose, on or after the age of 16 years.)

PRINT NAME OF LICENSED MEDICAL PRACTITIONER | SIGNATURE OF LICENSED MEDICAL PRACTITIONER | DATE

U.S. State & License Number | Healthcare Facility

Section C: TUBERCULOSIS (TB) CLEARANCE *(To be completed by U.S. licensed medical practitioner.)* ↓ここも医師が記載

The student has been evaluated using the process set out in the State of Hawaiʻi DOH TB Clearance Manual and determined that the individual does not have TB disease as defined in section 11-164.2-2, Hawai`i Administrative Rules.

Please complete ONE of the following: 日本人（日本生まれ？）は1とNegative TB risk assessmentにチェック

1) ☑ State of Hawaiʻi Department of Health TB Screening/Risk Assessment Clearance Form F (page 3 below).
(If completed and cleared, Form must be attached)

TB Screening Date: ____________ Month Day Year NNegative TB risk assessment ☑

2) ☐ PPD Skin Test: ____________ Month Day Year ____________ Induration (mm) Negative Test for TB Infection ☐

(Note: The skin test must be read 48-72 hours after administration and must be documented in millimeters (mm).

3) ☐ Quantiferon Gold Test/Blood Test Result: ____________ Month Day Year Positive ☐ Negative ☐

4) ☐ Negative Chest X-Ray: ____________ Month Day Year

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PRINT NAME OF LICENSED MEDICAL PRACTITIONER | SIGNATURE OF LICENSED MEDICAL PRACTITIONER | DATE

U.S. State & License Number | Healthcare Facility

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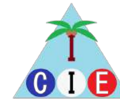
Sample!!!

TB Document F: State of Hawaii TB Clearance Form

Hawaii State Department of Health
Tuberculosis Control Program

Sample!!!



InWebOut Center for International Education
インウェブアウト留学センター
https://icie.jp/

Patient Name	DOB	TB Screening Date
Yoshio Tanaka	10/26/1999	

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Annual Screening for Health care facilities or residential care settings (*TB Document D*)
☐ Negative test for TB infection
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, and negative symptoms screen
☐ Previous positive test for TB infection, and negative CXR

Signature or Unique Stamp of Practitioner: ______________________________________
↑医者のサイン

Printed Name of Practitioner: ______________________________________
↑医者の名前（ローマ字）

Healthcare Facility: ______________________________________
↑病院名、住所、電話番号等

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.

TB Document G: State of Hawaii TB Risk Assessment for Adults and Children

Hawaii State Department of Health
Tuberculosis Control Program

Sample!!!

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☐ Yes ☐ No	**Does this person have significant TB symptoms?** Significant symptoms include cough for 3 weeks or more, 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

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

☐ Yes ☐ No	**Was this person born in a country with an elevated TB rate?** Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries. ココの枠に「Japan」がありませんが、2022年秋以降「Japan」が入ったそうですので、空欄に「Japan」と書いてNoにチェックを入れるようお医者様にお伝えください。
☐ 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)**
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Provider Name with Licensure/Degree:	**Person's Name and DOB:**
Assessment Date:	**Name and Relationship of Person Providing Information (if not the above-named person):**