MMR IMMUNIZATION VERIFICATION & TUBERCULOSIS CLEARANCE

FORM D

Student Information

Last Name/Surname	First Name	Middle Initial

Date of Birth (mm/dd/yyyy)	HPU Student ID Number

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

Student Signature **Date (MM/DD/YYYY)**

The following is to be completed by a US licensed practitioner/healthcare provider. Form must be completed in its entirety.

MEASLES, MUMPS, RUBELLA (MMR)

COMPLETE THE FOLLOWING:

First Dose		
Month	**Day**	**Year**

Second Dose		
Month	**Day**	**Year**

TUBERCULOSIS (TB)

COMPLETE ONE OF THE FOLLOWING:

Quantiferon Gold Test/Blood Test			
Month	**Day**	**Year**	**Result (Positive/Negative)**

OR

PPD Skin Test			
Month	**Day**	**Year**	**Induration (mm)**

Note: The skin test must be read 48-72 hours after administration and must be documented in millimeters (mm). Test results without the induration in millimeters will be rejected.

OR

Negative Chest X-Ray		
Month	**Day**	**Year**

OR

State of Hawai'i Department of Health TB Screening / Risk Assessment Form F (If completed and cleared, Form must be attached)		
Month	**Day**	**Year**

Name of Physician/Healthcare Professional **Signature** **Date**

U.S. State & License Number **State** **Zip Code**

Hawaii Pacific University
1 Aloha Tower Drive | Honolulu, Hawai'i 96813
Phone: (808) 544-0238 | Fax: (808) 544-1136

LOOK CLOSER. SEE FURTHER. DO MORE.

TDAP, MENINGOCOCCAL (MCV), VARICELLA (VCV) IMMUNIZATION VERIFICATION

FORM E

Student Information

Last Name/Surname | **First Name** | **Middle Initial**

Date of Birth (mm/dd/yyyy) | **HPU Student ID Number**

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

Student Signature **Date (MM/DD/YYYY)**

The following is to be completed by a US licensed practitioner/healthcare provider. Form must be completed in its entirety.

TDAP

Most Recent TDAP Dose		
Month	**Day**	**Year**

VARICELLA (VCV)

COMPLETE THE FOLLOWING:

First Varicella (VCV) Dose		
Month	**Day**	**Year**

Second Varicella (VCV) Dose		
Month	**Day**	**Year**

Varicella Exemptions:

- **Students born in the United States prior to 1980. (Must attach proof of date of birth to this form).**
- **A signed, documented diagnosis or verification of a history of varicella disease or herpes zoster by a practitioner. (Must attach verification to this form. Practitioners may use this form for verification).**

LIVING ON CAMPUS ONLY

Required for new students planning to live on-campus who are 21 years of age or younger.

MENINGOCOCCAL (MCV)

First Meningococcal (MCV) Dose		
Month	**Day**	**Year**

Name of Physician/Healthcare Professional **Signature** **Date**

U.S. State & License Number **State** **Zip Code**

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