

FALL 20____
SPRING 20____
SUMMER 20____

University of Hawai'i – West O'ahu
Office of Admissions
96-129 Ala'ike • Pearl City, Hawai'i 96782
Phone: 808.454.4837 • Fax: 808.453.6076
Email: admissions@uhwo.hawaii.edu

HEALTH CLEARANCE FORM

- Instructions: 1) Please complete the sections below and return this form to the Office of Admissions. 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 _____ SSN or UH ID _____
Last First Middle

Mailing Address _____ City _____ State _____ Zip code _____

Email Address _____ Daytime Phone _____ Birthdate ____ / ____ / ____

TUBERCULOSIS CLEARANCE REQUIREMENTS

- If attending a Hawai'i college for the first time, 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: _____

Printed Name of Physician/Clinic _____ Telephone No. _____

Official Signature _____ Date _____

MEASLES, MUMPS, RUBELLA (MMR) CLEARANCE REQUIREMENTS

- Proof of **TWO** doses of the Measles (Rubeola) vaccine, at least ONE must be the Measles, Mumps, Rubella (MMR) vaccine **OR**
- Positive Measles, Mumps, Rubella (MMR) IgG blood test report (copy of blood test report required)

For Physician's/Clinic Use Only:

Measles, Mumps, Rubella (MMR) Date of 1st Vaccine: _____

Date of 2nd Vaccine: _____

Printed Name of Physician/Clinic _____ Telephone No. _____

Official Signature _____ Date _____

OFFICE USE ONLY

SOAHOLD GOAMEDI SAAACKL

By/Date: _____