University of Hawai'i • Kapi'olani Community College
Kekaulike Information and Service Center (KISC)
4303 Diamond Head Road, 'Ilima 102 • Honolulu, Hawaii 96816-4421
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FALL 20_____ SPRING 20_____ SUMMER 20_____

KAPI'OLANI COMMUNITY COLLEGE – HEALTH CLEARANCE FORM

Student Instructions:
1. Complete the box 1 by filling in your personal information.
2. Information in boxes 2 & 3 must be completed by a physician/clinic in the United States OR clear photocopies of your TB and/or MMR immunization or test results must be submitted.
3. Health clearances must be submitted before registration for ALL new, transfer, and returning students or registration will not be allowed.

Physician's/Clinic's Instructions:
1. Complete boxes 2 & 3. Be sure to sign and stamp/seal each section you complete.

Box 1 - Student Information:

Name _____ UH Number/Username _____
Last Name *First Name* *M.I.*

Email Address _____ Daytime Phone _____ Birthdate ____/____/19____

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.
- TB test and chest x-rays must be done in the continental U.S., Alaska, or Hawai'i. Tests or x-rays done anywhere else WILL NOT BE ACCEPTED.

Box 2 - For Physician's/Clinic's Use Only:

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

OR

CHEST X-RAY (if skin test is positive) Date x-ray taken:_____ Results (normal/abnormal):_____

M.D. or R.N. Signature _____ Official Stamp _____

Printed Name & Title_____ Date _____ Telephone No._____

MEASLES,MUMPS, AND RUBELLA (MMR) CLEARANCE REQUIREMENTS (One of the following):

- Proof of **one** dose of the Measles (Rubeola) vaccine, and **one** dose of Measles/Mumps/Rubella (MMR) vaccine, ***OR***
- Proof of **two** doses of the Measles/Mumps/Rubella (MMR) vaccinations, ***OR***
- Positive Measles Mumps Rubella (MMR) IgG blood test report if student had diseases, or if vaccines were administered, but no record is available (Physician in the United States must review and sign report below), ***OR***
- Student was born before 1957.
  Note: Vaccines should be one month apart, given on or after January 1, 1968; and/or after the student's first birthday.

Box 3 - For Physician's or Clinic's Use Only:	**DATE OF IMMUNIZATION**		**TITER TEST**
VACCINE	**#1**	**#2**	**Attach signed (by the M.D. or R.N.) photocopy of the Positive IgG Blood Test Results for Mumps Measles Rubella (MMR).**
Measles *OR*	/ /	**MMR Required**	
Mumps Measles Rubella (MMR)	/ /	/ /	

M.D. or R.N. Signature_____ Official Stamp_____

Printed Name & Title _____ Date _____ Telephone No. _____

FOR OFFICE USE ONLY UH Number: _____ ☐ SOAHOLD ☐ GOAMEDI By/Date: _____

This form may be rejected if it is not fully completed and signed in both sections by a M.D. or R.N. in the United States (other than your spouse, parent, or self). If a copy of TB Card or lab report is attached, then no signature is required on this form.

KISC Rev. 04/13