



POLICY & INSTRUCTIONS

The State of Hawaii Department of Health requires that all students meet immunization and tuberculosis examination requirements before attending any post-secondary school in Hawaii. *Certain exemptions apply. (Please see page 5 for more details).*

Chaminade University of Honolulu requires student health information for use in emergency or epidemic situations. ****Access to this information will be provided to the Chaminade University Counseling Center and the Residential Life office.****

While Chaminade University does not provide on-campus health services, there are nearby medical practitioners and clinics who provide basic services, immunizations, and lab testing for a fee.

HEALTH REQUIREMENTS CHECKLIST

THE FOLLOWING REQUIREMENTS MUST BE MET AND SUBMITTED BY ALL ADULT EVENING/ONLINE & GRADUATE STUDENTS:

- Student Information
- Self-Reported Medical History
- Student Verification Signature
- Immunization & Tuberculosis Examination Form

Please send all documents to: Chaminade University of Honolulu
ATTN: Student Support Services
3140 Waialae Ave.
Honolulu, HI 96816

Documents may also be faxed to (808) 735-4752. Please complete this form and submit *before your first term at Chaminade and no later than the third week of instruction.* **Questions or Concerns?** Please contact Student Support Services at (808) 735-4724, Monday-Friday, between the hours of 8am-4:30pm HST.



Student Information

Last Name: _____ First Name: _____

Date of Birth: ____ / ____ / ____ (Month/Day/Year) Sex: Male Female

Address: _____
Address City/State/Zip

Country of Origin: _____ Phone Number: (____) _____

Primary Email: _____ Chaminade ID no. _____

Entering Term (Please Circle One) & Year: Fall Winter Spring Summer 20____

For Office Use Only

Date Received:

Status: Clear Not Clear

Missing Documents: TB MMR Other

Self-Reported Medical History

Please answer ALL questions to the best of your knowledge. Please state N/A if not applicable.
All information submitted will be held in confidentiality.

A. Please check any of the following Health Conditions that you have had or now have:

- | | | | |
|---|--|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Malaria | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Asthma | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Clinical Depression | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Epilepsy | Other (Please Specify): | |

Allergies (Please Identify):

Other significant medical conditions which require regular visits to a physician:

B. Prescription Medication

1. Are you currently taking any prescribed medication on a regular, ongoing basis? Yes No
 If YES, please identify medications below:
2. Have you made arrangements for refills of medication while at Chaminade? Yes No
 If NO, please explain how you are going to obtain refills below:

C. Conditions which may impact mobility, require special care or assistance, or which may limit participation or require accommodating at University events, field trips, etc. Please note that if you require ADA accommodations, please contact the Chaminade Counseling Center at (808) 735-4845.

Student Verification of Information

I certify that, to the best of my knowledge, the answers to all questions are correct and that I have read the policy and instructions of Chaminade University and the Hawaii State Department of Health. Any evidence in the future that this form has been falsified or incomplete may be grounds for immediate suspension from Chaminade University. Chaminade reserves the right to reject or overturn acceptance for admission to the University if information on this form would indicate a need for such action. I understand that failure to complete this form in full and to return it to Student Support Services prior to the compliance deadline may result in the University preventing me from completing my registration for classes, assuming occupancy in the residence halls and/or participating in university-related events and athletics. I understand that I am also responsible for having an authorized health professional sign the immunization portions of this health form.

 Signature of Student

 Date

IF STUDENT IS UNDER 18 YEARS OF AGE, A PARENT OR LEGAL GUARDIAN MUST SIGN THE FOLLOWING:

I hereby authorize admission to the hospital in case of emergency and agree that the attending physician may, in case of extreme emergency, operate and/or administer the necessary anesthesia if the undersigned cannot be contacted.

 Signature of Parent or Legal Guardian

 Date

Tuberculosis & Immunization Verification

*****PLEASE READ THIS PORTION CAREFULLY*****

1. **A medical professional (U.S. Licensed, MD, DO, APRN, or PA) must complete and sign or stamp the contents of this page.**
2. **OR You may attach a copy of your records of your examinations and immunizations, signed or stamped by an MD, DO, APRN, or PA. This record must include complete dates (month/day/year).**

****Laboratory evidence of immunity may be substituted for a record of immunizations. A laboratory report signed by an MD, DO, APRN, or PA certifying immunity is required.*

TB/PPD: Mantoux Tuberculin Skin Test

**Marianist Exchange program students do not need to provide a copy of their tuberculosis clearance.*

- A certificate of Tuberculosis (TB) examination is required before post-secondary education in any course longer than 6 months. This requirement may not be deferred or postponed.
- The test must have been given within 12 months prior to first attending post-secondary education in Hawaii.
- Certificate of TB examination may be issued by the Hawaii Department of Health or a U.S. licensed MD, DO, APRN, or PA.
- If transverse diameter of induration (raised skin reaction) is 10mm or greater, a chest x-ray is also required. Students with previous positive PPD, may have a chest x-ray without a repeat skin test.

Date Given	Date Read	Results (MM)
Date:	Date:	

Print Name of Authorized Medical Professional completing this form. **Please Circle One: MD DO APRN PA**

Signature/Stamp of Medical Professional completing this form.

Contact Information: Address/City/State/Zip/Phone

MMR: Measles, Mumps, Rubella Vaccine

- You must provide documentation of any of the following:
 - 1) Two doses of measles-containing vaccine, with at least one of the two being Measles-Mumps-Rubella (MMR) vaccine. The first dose must have been given on or after 12 months of age and the second must have been given at least four weeks after the first dose.
 - 2) OR Record of positive Measles Titer, Mumps Titer, and Rubella Titer. A laboratory report, signed by an MD, DO, APRN, or PA certifying that the student is immune to the specified diseases is required.
- Students born prior to 1957 are exempt from the measles, mumps, and rubella requirement.

Measles Verification	Mumps Verification	Rubella Verification
Date:	Date:	Date:
Date:	Date:	Date:

Print Name of Authorized Medical Professional completing this form. **Please Circle One: MD DO APRN PA**

Signature/Stamp of Medical Professional completing this form.

Contact Information: Address/City/State/Zip/Phone

MMR TITER:

If you are unable to provide dates for your MMR vaccine you will need to order an MMR titer (blood test). Please submit a copy of the laboratory report, signed/stamped by an MD, DO, APRN, or PA with a note certifying immunity to measles, mumps, and rubella. If your results are NOT positive (i.e. you are not immune) you will need to get two doses of the MMR vaccine.