

CHAMINADE UNIVERSITY OF HONOLULU  
Student Support Services  
**Adult Evening & Online Programs  
and Graduate Programs  
STUDENT HEALTH FORM**

*Updated 5.19.08*

**\*\*DUE PRIOR TO THE THIRD WEEK OF INSTRUCTION\*\***

## **Policy and Instructions**

The State of Hawaii Department of Health, requires all students to meet immunization requirements before they attend any post-secondary school in the state.\*

The University requires the following health information for use in emergency or epidemic situations.

- Student Contact Information
- Certification of Mantoux Tuberculin Test
- Evidence of Measles, Mumps and Rubella Vaccination

While Chaminade does not provide on-campus health services, a student who does not have a record of testing or vaccination may contact Student Support Services (808.735.4733) for a list of agencies that do the testing for free.

### **IMPORTANT HEALTH INSURANCE INFORMATION:**

It is your responsibility to ensure that your current health insurance will be accepted in the State of Hawaii. If you would like to purchase the Chaminade University Student Health Plan, contact Student Support Services for an application or go online at [www.hmsa.com/portal/student](http://www.hmsa.com/portal/student). All international students are required to have health insurance.

All students, regardless of coverage, are responsible for all emergency medical fees incurred as a result of accident or illness. Chaminade University reserves the right to determine the need for emergency medical support on your behalf without assuming obligation for expenses from such support.

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

**Documents may also be faxed to: (808) 735-4752**

Please complete this form and submit it **no later than third week of instruction**. Failure to meet all requirements will result in your inability to register for future classes.

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**Questions?** Please call Student Support Services at (808) 735-4724.

\* Distance learning students who do not reside on the island of O'ahu are exempt from this policy.

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# **Immunization & Tuberculosis Examination Form**

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

**\*\*This portion will need the signature or stamp of a U.S. Licensed MD, DO, APRN, or PA.**

- \*\*Options:**
- 1.** A medical professional (MD, DO, APRN, or PA) must complete and sign or stamp contents of this portion.
  - 2. OR** You may attach a copy of your records of tuberculosis examination and immunizations, signed or stamped by a MD, DO, APRN, or PA. This record must include complete dates (month/day/year). *Laboratory evidence of immunity to Measles, mumps, and rubella may be substituted for a record of immunizations. A laboratory report, signed by an MD, DO, APRN, or PA certifying that the student is immune to the specified diseases is required.*

## **Mantoux Tuberculin Skin Test (TB/PPD)**

### ***Hawaii State Regulation:***

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

## **MMR: Measles, Mumps, Rubella Vaccine**

### ***Hawaii State Regulation:***

- You must provide documentation of any of the following:
  - i) 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 4 weeks after the first dose.
  - ii) OR record of positive Measles Titer, Mumps Titer, and Rubella Titer. This must be supported with laboratory evidence of immunity to measles, mumps and rubella. *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 immunization requirement.

**Please send all documents to:**

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Any questions please call: (808) 735-4724

**Adult Evening & Online Programs and Graduate Programs  
STUDENT HEALTH FORM**

For Office Use Only  Date Received:  _____
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Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Chaminade University Student ID No. \_\_\_\_\_

Entering Term (Please check one) & Year :  Fall  Spring  Summer  Winter 20\_\_

**Mantoux Tuberculin Skin Test (TB/PPD)**

**10 MM or GREATER REQUIRES A CHEST X-RAY**

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

**Medical Professional Signature or Stamp for TB Information**

Please Circle One: MD DO APRN PA

\_\_\_\_\_  
Print name of Authorized Medical Professional completing this form

\_\_\_\_\_  
Signature/Stamp of Professional Completing this Form      \_\_\_\_\_  
Contact Information: Address/ Phone

**MMR: Measles, Mumps, Rubella Vaccine**

Measles Vaccination	Mumps Vaccination	Rubella Vaccination
Date: _____	Date: _____	Date: _____
Date: _____	Date: _____	Date: _____

OR

**This portion requires a copy of the laboratory report, signed/stamped by an MD, DO, APRN, or PA certifying that the student is immune to the specified diseases.**

Measles Titer	Mumps Titer	Rubella Titer
Date: _____	Date: _____	Date: _____
Results: Positive / Negative	Results: Positive / Negative	Results: Positive / Negative

**Authorized Medical Professional Information for MMR**

Please Circle One: MD DO APRN PA

\_\_\_\_\_  
Print name of Authorized Medical Professional completing this form

\_\_\_\_\_  
Authorized Medical Professional Signature/Stamp      \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Professional Completing this Form      \_\_\_\_\_  
Contact Information: Address/ Phone

*CONTINUE TO NEXT PAGE*

# STUDENT VERIFICATION

I certify that, to the best of my knowledge, the answers to all questions are correct. I understand that failure to complete this form in full and to return it to the University prior to the third week of instruction at the University may result in the University preventing me from completed my registration for classes or continuing in classes. I also understand I am responsible for having an authorized health professional sign the immunization portions of the health form. Any evidence that this form has been falsified or incomplete may be grounds for dismissal from the University. Lastly I have read the policy outlined on page one of this report.

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Student Signature

Date