



HEALTH CENTER

IMMUNIZATION AND TUBERCULOSIS CLEARANCE REQUIREMENTS

Dear Student:

The Hawaii State Department of Health (DOH) requires all university students to have had 2 doses of the MMR (Measles, Mumps, Rubella) vaccine or provide laboratory evidence of immunity to measles, mumps and rubella. The DOH also requires tuberculosis (TB) clearance before class attendance. You may get a TB skin test upon arrival at BYU – Hawaii or at your physician’s office, provided all criteria on the “Tuberculosis Clearance Form” are met. The form is included with this letter. If you are planning on getting your TB test at BYU – Hawaii, please do not get an MMR vaccine less than 30 days prior to arriving on campus.

Please fax all documentation of your MMR immunizations or equivalent to (808) 675-3506 or mail it to BYU – Hawaii, Health Center, 55-220 Kulanui St., #1728, Laie, HI 96762.

Once your completed immunization record has been received and approved, you will be able to proceed with your registration. Failure to complete your state health immunizations or provide the necessary information to the Health Center may delay your registration or approval to attend class.

Former students who are returning to school may call the Health Center to check on your state health immunization status. Your requirements may have already been met, and we may be able to clear you for registration by phone.

If your country does not provide the MMR vaccine, please have your physician complete the bottom section of the “State Health Immunization Requirement” form which is enclosed.

If you have any questions, please contact our office at (808) 675-3510.

Sincerely,

A handwritten signature in black ink that reads "P. Douglas Nielson, MD".

P. Douglas Nielson, MD
Medical Director of Health Services

STATE HEALTH IMMUNIZATION REQUIREMENTS

Return forms to: BYU – Hawaii Health Services * 55-220 Kulanui Street #1916 * Laie, HI 96762-1294
Ph.: (808) 675-3510 * Fax: (808) 675-3506

Legal Name (Last):	(First):	BYU – H Student I.D. #:
Semester/Term Entering: (Year)	Date of Birth: Month / Day / Year	Social Security Number:

THIS FORM MUST BE COMPLETED AND SIGNED BY A MEDICAL DOCTOR OR REGISTERED NURSE

All information must be in English. If you have a completed immunization card signed by the providers that gave the immunizations or a recent completed school record, you may mail or fax a photocopy in place of this completed form.

A. MMR (Measles, Mumps & Rubella) (two doses required)	#1 Mo. Day Yr.	#2 Mo. Day Yr.
Dose 1 given at 12 months of age or later and Dose 2 given after age 4 or no later than 30 days prior to arrival on campus	____/____/____	____/____/____
If requirement A is not met, then B, C and D must be met.		
B. Measles (Rubeola) (two doses required) (Complete all that apply)	#1 Mo. Day Yr.	#2 Mo. Day Yr.
Immunized with live measles vaccine at 12 months of age or later AND after age 4	____/____/____	____/____/____
Has report of positive immune titer. Specify date.	Mo. Day Yr. ____/____/____	
Had disease confirmed by doctor's records.	Mo. Day Yr. ____/____/____	
C. Rubella (German Measles) (two doses required) (Clinical history is not acceptable) (Complete all that apply)	#1 Mo. Day Yr.	#2 Mo. Day Yr.
Immunized with live vaccine at 12 months of age or later AND after age 4	____/____/____	____/____/____
Has report of positive immune titer. Specify date.	Mo. Day Yr. ____/____/____	
D. Mumps (two doses required) (Complete all that apply)	#1 Mo. Day Yr.	#2 Mo. Day Yr.
Immunized with live vaccine at 12 months of age or later AND after age 4	____/____/____	____/____/____
Has report of positive immune titer. Specify date.	Mo. Day Yr. ____/____/____	
Had disease confirmed by doctor's records.	Mo. Day Yr. ____/____/____	

E. Tuberculosis – PPD WILL BE GIVEN UPON ARRIVAL TO CAMPUS (make sure your MMR is received no later than 30 days prior to arrival on campus)

The MMR is not available in _____. I agree to get my first MMR upon arrival and my second MMR four week later at a cost of \$75.00 each.
(Name of country)

Signature: _____ Date: _____
(Student)

HEALTH CARE PROVIDER SIGNATURE (Must be a Medical Doctor or Registered Nurse)

(Print) Name of Physician or R.N. Signature Date

Address: _____
Street City State/Country Zip Code Phone



HEALTH CENTER

Tuberculosis (TB) Clearance

Your tuberculosis skin test must meet ALL of the following criteria set by the Hawaii State Department of Health to be valid.

1. Must be done in the United States
2. Must be taken within 12 months of school start date
3. Must be a PPD test (Mantoux)
4. Must list date given and date read in millimeters. The word "negative" or "positive" is **not** acceptable.
5. Must be signed by an MD, DO, PA or advanced practice nurse
6. If your PPD test is **positive** (10 mm or greater), in addition to the above information, a chest x-ray is required. The chest x-ray must be done in the United States.
 - a. Attach a copy of your chest x-ray report
 - b. The x-ray report **must** contain the wording "**no evidence of tuberculosis**" to be acceptable.

Last Name _____ First Name _____ Birthdate: _____ BYUH ID # _____
Print Print

Medical provider to complete:

PPD date given:	
PPD date read:	
Millimeter (mm) reading:	
Referred for chest x-ray? (Attach copy of x-ray report)	
Print MD, DO, PA or nurse name:	
Address Stamp:	
MD, DO, PA or nurse signature:	
Date:	

Please fax this form to the BYU – Hawaii Health Center at (808) 675-3506.