BYU-Hawaii IMMUNIZATION CLEARANCE FORM (Page 1 of 2)

The State of Hawaii Department of Health (DOH) Hawaii Administrative Rules, Title 11 (Chapters 157 and 164.2) requires certain health requirements be met for attendance to a post-secondary institution. In addition, BYU-Hawaii is requiring COVID-19 vaccination. Registration is not allowed until all health clearances are met and submitted to Health Services. *This form may be rejected if it is not fully completed and signed by a licensed medical practitioner*. A practitioner is a licensed physician, advanced practice registered nurse (APRN) or physician assistant (PA). A medical record of vaccination is also acceptable.

Legal Name (Last):		(First):		BYU – H Student I	D. #:	
Semester/Term Entering	g: (Year)	Date of Birth: Mont	h Day Year			-
			/ /			
						_
A. Measles, Mumps,	Rubella (MMR) (two dose	S) No titers accepted.				
#1 Mo. Da	y Yr.	#2 Mo. Day Yr.	OR Born	before 1957 (exempt from M	IMR vaccine)	
				, ,	,	
B. Tetanus, diphtheri	ia, pertussis (Tdap) Must b	oe administered on or after age	10. No titers accepted.			
Tdap booste	#1 Mo. Day Yr.				Tdap was licensed for use in the U.S. i prior to 2005 should not be counted.	in
C. Varicella (Varivax)	(two doses required or o	linical history) Varivax &	MMR should be received no	later than 30 days prior to	arrival on campus. No titers accepte	d.
#1 Mo. Day	Yr.	#2 Mo. Day Yr.	ORBorn	before 1980 in U.S. (exempt	from Variable vaccine)	
/Dose 1 receive	/ d after age 12 months, dose 2 at l	/	_	ory of Varicella disease.	Mo. Day Yr.	
				·		
	 Complete separate for days of arriving on camp 		I UPON ARRIVAL ON	CAMPUS but <u>do not</u> ç	jet the MMR or Varicella	
	dents, have your provider se ensure you do not get				test (PPD) when you come us.	to
	students, you will receive an TB medications in your co				n abnormal PPD or chest x-ray completed your PPD.	/
E. If MMR, Tdap, Varice	ella, COVID-19 or MCV vacci	ne is not available in you	r country, please have y	our physician complete	the bottom of this form.	
The MMR, Tdap, Varic vaccinations according the cost.	ella, COVID-19 or MCV va to the schedule recommer	ccine is not available in (nded by the Centers for I	country) Disease Control when I	I arrive on campus, and	will receive the needed I am financially responsible for	ſ
Signature:				Date:		_
	(Stud	ent)				
Н	EALTH CARE PROV	IDER SIGNATURE	(Must be a physicia	an (MD or DO). PA	or APRN)	
			nplete in English	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	
(Print) Nam	e of Provider		Signature		Date	
Address: Str	reet	City	State/Country	Zip Code	Phone	
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BYU-Hawaii IMMUNIZATION CLEARANCE FORM (Page 2 of 2)

Legal Name (Last):	(First):		BYU – H Student I.D. #:						
Semester/Term Entering: (Year)	Date of Birth: Mor	nth Day Year							
		/ /							
☐ Yes ☐ No Residing in on-campus housing									
☐ Yes ☐ No First-year student age 21 years or younger									
If yes to both, please have a medical practitioner (licensed physician, advanced practice registered nurse (APRN) or physician assistant (PA)) complete this form. A medical record of vaccination is also acceptable.									
Meningococcal Conjugate Vaccine (MCV) Must be administered on or after age 16 years									
#1 Mo. Day Yr.									
HEALTH CARE PROVIDER SIGNATURE (Must be a physician (MD or DO), PA or APRN)									
Please complete in English									
(Print) Name of Provider	Signature Date			* : :					
Address: Street	City	State/Country	Zip Code Phone						