Please submit all required documents listed below by June 1, 2018

If you are unable to fulfill any requirements by June 1, 2018, you are required to submit a letter with your packet to the Office of Experientials explaining your situation and the expected date(s) of completion for each requirement.

KEEP A COPY OF ALL DOCUMENTS FOR YOUR RECORDS

1. Tuberculosis Clearance
   - 2-step Mantoux tuberculin skin test (PPD)
     - 2-Step skin test must be performed after September 2017 within the United States or its territories.
     - A 2-Step requires that you get two PPD skin tests; the second one should be administered AT LEAST 7 days after the 1st PPD is given
     - PPD documentation must include: date given, date read, and test results in mm
     - Do NOT receive an MMR vaccination before or during a PPD skin test, this could lead to a false positive
   - Chest X-ray – Only required for those with a positive PPD reading (≥ 10 mm) or history of a positive PPD
     - Date of positive reading and mm size is required along with Chest X-ray report dated after September 2017

Refer to http://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm for additional information on Tuberculin Skin Testing

2. Hepatitis B
   - Positive/Reactive Hepatitis B Surface Antibody Titer- Quantitative (HBsAb)
     - Laboratory Results must include reference ranges and be on laboratory letterhead.
     - Laboratory titer should be done at least 4 weeks after last vaccination
     - If immunity is not present according to serum blood titer, student must receive a 4th Hepatitis B (challenge dose) followed by another serum blood titer 1 to 2 months later; if antibody titer is still negative, receive the remaining 2 doses of a second series and test blood serum again, as indicated per CDC recommendation.

Refer to http://www.cdc.gov/vaccines/pubs/pinkbook/hepb.html for additional information on Hepatitis B requirements.

3. Measles/Mumps/Rubella (MMR)
   - 2 MMR immunizations (at least 28 days apart, Childhood records will suffice)
   - OR
   - Positive/Reactive Measles Titer- Quantitative (IgG)
   - Positive/Reactive Mumps Titer- Quantitative (IgG)
   - Positive/Reactive Rubella Titer- Quantitative (IgG)
     - Laboratory Results must include reference ranges and be on laboratory letterhead.

Refer to http://www.cdc.gov/vaccines/pubs/pinkbook/meas.html for additional information on Measles requirements.
Refer to http://www.cdc.gov/vaccines/pubs/pinkbook/mumps.html for additional information on Mumps requirements.
Refer to http://www.cdc.gov/vaccines/pubs/pinkbook/rubella.html for additional information on Rubella requirements.

4. Varicella
   - 2 Varicella immunizations (at least 28 days apart, Childhood records will suffice)
   - OR
   - Positive/Reactive Varicella Titer- Quantitative (IgG)
     - Laboratory Results must include reference ranges and be on laboratory letterhead.

Refer to http://www.cdc.gov/vaccines/pubs/pinkbook/varicella.html for additional information on Varicella requirements.

5. Tetanus
   - Tdap (tetanus/diphtheria/pertussis)
   - AND
   - 2 additional tetanus vaccinations- Td / Tdap / DPT / DT / DTaP / DTP (Childhood records will suffice)
     - 1 of the tetanus vaccinations needs to be within 10 years
     - If no documented history- Receive a Tdap, followed by a Td booster 4 weeks later, and another Td booster 6 months later

Refer to http://www.cdc.gov/vaccines/pubs/pinkbook/tetanus.html for additional information on tetanus requirements.

Please contact Christina Method at DKICP Office of Experientials if you have any questions.
Email: method@hawaii.edu   Phone: (808) 932-7709
**TB and Immunization Clearance Form**

This page can be used for documentation of past immunization history IF a **physician signs off** on all requirements below. **If you have supporting tuberculosis and immunization documentation this page is optional**

Laboratory reports are still **required AND** must include reference ranges and be on laboratory letterhead.

Last Name: ____________________ First Name: ____________________ Middle Name: ____________________

BIRTHDATE: ____________________ UH ID #/SSN: ____________________

(enter ‘none’ if no middle name)

### Tuberculosis (PPD) 2-Step:

<table>
<thead>
<tr>
<th>PPD #1</th>
<th>PPD#2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Given: ________ Date Given: ________</td>
<td>Date Read: ________ Date Read: ________</td>
</tr>
<tr>
<td>Result: ________ mm Result: ________ mm</td>
<td></td>
</tr>
</tbody>
</table>

**OR**

If Positive PPD (>10 mm)

| Date of Positive PPD: ________ Result: ________ mm |
| Chest X-Ray Date: ________ Result: ________ |

*attach Chest X-ray report

### Hepatitis B Quantitative TITER:

| Date: ________ Result: ________ |

*attach lab report

If titer is negative, receive 4th Hep B (challenge dose) then re-titer 1-2 months later.

Hep B #4 Date: ________

Hep B TITER Date: ________ Result: ________

*attach lab report

If titer is still negative, receive remaining 2 doses of Hep B series (0, 1, & 6 months) and re-titer 1-2 months later.

Hep B #5 Date: ________

Hep B #6 Date: ________

Hep B TITER Date: ________ Result: ________

*attach lab report

### Measles/Mumps/Rubella (MMR):

| Measles IgG Titer Date: ________ Result: ________ |
| Mumps IgG Titer Date: ________ Result: ________ |
| Rubella IgG Titer Date: ________ Result: ________ |

*attach lab report

**OR**

MMR Vaccine #1 Date: ________

MMR Vaccine #2 Date: ________

### Varicella:

| Varicella IgG Titer Date: ________ Result: ________ |

*attach lab report

**OR**

Varicella Vaccine #1 Date: ________

Varicella Vaccine #2 Date: ________

### Tetanus:

*attach lab report

2 tetanus **AND** 1 Tdap are required (total of 3).

1 tetanus vaccination must be within 10 years.

Tdap Date: ________

Tetanus #2 Date: ________

Td / Tdap / DPT / DT / DTaP / DTP (circle one)

Tetanus #3 Date: ________

Td / Tdap / DPT / DT / DTaP / DTP (circle one)

### Notes:
_________________________________  ___________________________________  ______________

Health Care Provider Name **(Please Print)**  Health Care Provider **Signature**  Date

____________________________________
Health Care Provider Address and Phone Number