



UNIVERSITY OF HAWAII AT HILO
THE DANIEL K. INOUE COLLEGE OF PHARMACY
TB AND IMMUNIZATION CLEARANCE

The State of Hawaii mandates that certain health requirements be met for entrance to post-secondary educational institutions. (Hawaii Administration Rules, DOH Title 11, Chapter 157). In addition to these requirements, The Daniel K. Inouye College of Pharmacy (DKICP) also requires all students to comply with the health requirements of its affiliated experiential sites.

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



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TB AND IMMUNIZATION CLEARANCE FORM

KEEP A COPY OF ALL DOCUMENTS FOR YOUR RECORDS

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: _____
(enter 'none' if no middle name)

Birthdate: _____ UH ID #/SSN: _____

Tuberculosis (PPD) 2-Step:

PPD #1: _____ PPD#2: _____
 Date Given: _____ Date Given: _____
 Date Read: _____ Date Read: _____
 Result: _____ mm Result: _____ mm

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:

*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