# UNIVERSITY OF THE NATIONS | YWAM KONA

## Adult Student Health Form

The State of Hawaiʻi Department of Health (DOH) Hawaiʻi Administrative Rules, Title 11 (Chapter 157 and 164.2) requires certain health requirements be met for attendance to an educational institution. *This form may be rejected if the mandatory vaccination and health history sections are not fully completed and signed by a licensed medical practitioner*. ***International students need to submit records in English for review by our U.S. licensed medical practitioner.*** No Student may attend class until they have received Health Clearance from Campus Health. For Student Health Form or vaccination questions, email campushealth@uofnkona.edu.

## INSTRUCTIONS FOR COMPLETION OF THIS FORM

**1) TUBERCULOSIS (TB) CLEARANCE (Required)**

a. Prior to completing the Student Health Form, complete the Tuberculosis Questionnaire in your student application. After your answers are reviewed by Campus Health staff, an email will be sent to you with further instructions.

**2) IMMUNIZATION CLEARANCE (Required)**

a. MMR-MEASLES (Rubeola), MUMPS, AND RUBELLA VACCINES: Two MMR doses are required, administered at least 4 weeks apart. If you do not have access to your vaccination records, you may instead submit laboratory evidence of immunity (positive blood titers) to ALL THREE diseases rather than having proof of vaccination. You must submit the original laboratory results with this health form. If you were born before 1957, you are exempt from the MMR requirement.

b. TDAP- (TETANUS, DIPHTHERIA, ACELLULAR PERTUSSIS) VACCINE: Your last dose must have been administered after the age of 11 years old and within the past 10 years. If your record is not within the last 10 years, you will need a booster injection. Td is not an acceptable alternative to Tdap vaccination.

c. VARICELLA (CHICKEN POX) VACCINE: Two vaccine doses are required, administered at least 4 weeks apart. If you had Varicella disease, your healthcare provider must document history of the disease and provide a signature. If you were born in the U.S. before 1980, you are exempt from the Varicella vaccination requirements. If you do not have access to your vaccination records, you may instead submit laboratory evidence of immunity (positive blood titer) to Varicella disease rather than having proof of vaccination. If a blood titer was drawn, you must submit the original laboratory results with this health form.

d. MENINGOCOCCAL CONJUGATE VACCINE (A, C, Y, W-135) One dose is required for students ages 16-21. The vaccination must have been administered on or after the age of 16 years old. If one dose was administered before 16 years, a second dose is necessary.

**3) TRAVEL IMMUNIZATIONS (Recommended)**

a. Travel immunizations are highly encouraged, but are not mandatory for attendance to the lecture phase in Hawaii. Any individual wishing to participate in outreaches to any international locations or outreaches that work with vulnerable populations are **required** to complete the recommended travel medications and immunizations pertaining to their outreach location.

b. There will be opportunity to get these travel immunizations in Hawaii after learning your outreach location, however, they will be given all at one time. In addition, vaccines may be less expensive in your current place of residence, especially if you are an international student.

**4) STUDENT HEALTH CLEARANCE (Required)**

a. Please complete the required Student Health Form and have it signed by a licensed Medical Doctor, Physicians Assistant or Nurse Practitioner. **All records must be in English.**

b. Once the Student Health Form is completed, please upload it to your online application in PDF form. Campus Health will then review your form and grant you health clearance based on its completion.
INDIVIDUALS MAY NOT ATTEND CLASS UNTIL A HEALTH FORM HAS BEEN SUBMITTED.

# UNIVERSITY OF THE NATIONS | YWAM KONA

## Student Health Form

I give permission to my healthcare provider to disclose the requested medical information and records on this document to the University of the Nations, Kona. I understand that I am giving the University my private information and authorize the University to disclose or share confidential information with any third party when deemed necessary by the University. I understand I have the authority to revoke this authorization at any time by sending a written notice to campushealth@uofnkona.edu.

**Student Signature:**____________________________________________**Date:**________________________

**Printed Name:**______________________________________________________________________

**School:**____________________________________________________**Date of Birth:**___________________

**1. Do you have any previous or current medical conditions? Please list the condition/s and year you were first treated.**

__________________________________________________________________________________

__________________________________________________________________________________

**2. List all current prescribed medications you take (daily and as needed) including name, dosage, and frequency.**
*Please note, the use of medical marijuana, illegal substances, and/or unauthorized use of prescription medications is not allowed while enrolled in any program of study at University of the Nations--YWAM Kona.

__________________________________________________________________________________

__________________________________________________________________________________

**3. List any allergies you have and your reaction.**

__________________________________________________________________________________

**Do your allergies require the use of an Epipen/epinephrine injection? (Circle) Yes / No**

**4. Do you have any previous or current mental health conditions?** (including addiction, anxiety, bipolar disorder, depression, eating disorders, schizophrenia, etc.)

__________________________________________________________________________________

__________________________________________________________________________________

**5. In the past three years, have you had depression or anxiety that was treated by medication and/or counseling? If yes, please describe.**

__________________________________________________________________________________

__________________________________________________________________________________

**6. In the past three years, have you ever attempted to commit suicide or harm yourself or someone else? If yes, please describe.**

__________________________________________________________________________________

__________________________________________________________________________________

**7. Do you have any physical condition that would limit your ability to fully participate in outreach activities?** For example: walking long distances daily, hiking, going to a medically underserved area, etc.

__________________________________________________________________________________

__________________________________________________________________________________

# UNIVERSITY OF THE NATIONS | YWAM KONA

## Student Health Form

**For Medical Provider:** Please transcribe vaccination dates below then sign as an indication of your review. Please wait at least 28 days after administering a live virus vaccine (like MMR, Varicella, or Yellow Fever) before administering ANY additional immunizations OR doing any type of TB testing.

**Student Name:**_______________________________________________**Date of Birth:**____________________

### REQUIRED IMMUNIZATIONS- Write dates (MM/DD/YYYY)

**MMR** (2 doses) **#1** ____________ **#2** ____________

**OR**

❏ Positive Titers to Measles AND Mumps AND Rubella (must attach copy of lab results) ❏ Born before 1957 (exempt)

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**Varicella** (2 doses) **#1** ____________ **#2** ____________

**OR**

❏ History of Disease
❏ Positive Titer to Varicella (must attach copy of lab results)
❏ Born in the USA before 1980 (exempt)

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**MCV4** ____________ (must be administered at 16 years or older) Age at vaccination: ___________

**OR**

❏ Age 22 years or older (exempt)

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**Tdap** (cannot be Td only) ____________ (date must be within last 10 years)

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### SUGGESTED TRAVEL IMMUNIZATIONS

**Hepatitis A** (2 or 3 doses) **#1** ____________ **#2** ____________ **#3** ____________

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**Hepatitis B** (2 or 3 doses) **#1** ____________ **#2** ____________ **#3** ____________

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**Polio** (3 or 4 doses) **#1** ____________ **#3** ____________

❏ **IPV**

❏ **OPV** **#2** ____________ **#4** ____________ **Adult booster** ____________

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**Typhoid** ____________

❏ **Injectable** (date must be within last 2 years)

❏ **Oral** (date must be within last 5 years)

**Yellow Fever** (1 dose) ___________

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**Provider Signature:(MD,DO,PA,NP)**_____________________________________________

**Printed Name, Credentials & Date:**_____________________________________________

**Facility Name/Stamp:**_____________________________________________