



UNIVERSITY
OF HAWAII
HILO

HEALTH HISTORY FORM

RETURN TO:

UH Hilo
STUDENT HEALTH SERVICE
200 W. Kawili St.
HILO, HI 96720-4091
(808) 974-7636
FAX: (808) 933-0868

This information is confidential and does not become part of your academic record. Please complete both sides and mail to the Student Health Service one month prior to expected enrollment date. Alternate format available upon request.

Name: _____ UH ID #: _____
Last (Family Name) First Middle

Permanent Home Address: _____

Local Address: _____
Street City State Zip (Country)

Local Phone #: (____) _____ Expected date of enrollment: Spring _____ (year)
Area Code Fall _____ (year)

Date of Birth: ____/____/____ Gender: F____ M____ Country of Birth: _____
Month Day Year

AUTHORIZATION AND CONSENT FOR TREATMENT OF MINORS

To be completed by Parent or Guardian if the student will be under the age of 18 when seeking health services from the University.

I, the parent/legal guardian of (print student's name)

_____,
 in consideration of the services rendered by the University of Hawai'i at Hilo Student Health Services (hereafter UHSHS), hereby voluntarily, and knowingly authorize and give my express consent to the UHSHS for the administration of medical treatment for minor illnesses or injuries and emergency care to the above named student as deemed necessary by the nurse on staff at UHSHS.

 SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

In Case of Emergency, Notify:

Name: _____
Last (Family Name) First Middle Relationship

Address: _____
Street City

Telephone: (____) _____
State Zip Code Area Code

Name and Address of Personal Physician:

Personal History

Have you had:	Y	N	Allergic to (list others):	Y	N	Surgery (specify):
Measles Disease (rubeola)			Aspirin			
German Measles Disease			Penicillin			
Mumps Disease			Sulfa			
Chicken Pox						
Malaria						
Tuberculosis						

Please elaborate on all "yes" answers.

A. Has your physical activity been restricted during the past five years? (Give reasons and durations.)

B. Have you received treatment or counseling for an alcohol, drug related or emotional problem? (Give details.)

C. Do you have a history of any severe or chronic condition? (Give details)

D. Do you have any type of handicap or condition which limits function? (Give details)

Y N

OVER

IMMUNIZATION RECORD

NAME: _____ Birthdate: _____ UH ID#: _____

The State of Hawai'i mandates that certain health requirements be met for entrance to post-secondary educational institutions. (Hawai'i Administration Rules, DOH Title 11, Chapter 157) You may not register until these requirements are met.

***I. TUBERCULOSIS CONTROL:**

U.S. STUDENTS: A Tuberculin skin test (PPD-Mantoux) within one year prior to enrollment. If positive, a chest x-ray is required. **OR** Chest x-ray done in the **United States** within one year of enrollment.

PPD (MANTOUX): Date Given: _____ Date Read: _____ Results (in mm): _____

CHEST X-RAY (if skin test is positive): Date X-Ray taken: _____ Results: _____

INTERNATIONAL STUDENTS: All students must have a skin test performed within the United States or its Territories. Submit health forms by the required deadline without the tuberculin test results. Upon arrival on campus, skin tests are given at the Student Health Service. A follow up x-ray may be required.

***II. MEASLES (Rubeola), MUMPS, RUBELLA (German Measles):** Two doses of live measles vaccine are required, with at least one of the two being an MMR (Mumps, Measles, and Rubella). **First dose must have been given after January 1, 1968, and on or after first birthday**, and second dose must have been given at least 4 weeks after the first dose. Measles, Mumps and Rubella immunization may be waived if: 1) Student was born before 1957 or 2) Serologic evidence of immunity to measles, mumps, and rubella.

COMPLETE ONE OF THE FOLLOWING:

1. Proof of two MMR immunizations: Date 1) _____ / _____ / _____ 2) _____ / _____ / _____
(Mo) (day) (year) (Mo) (day) (year)
2. Measles (Rubeola) vaccine 1) _____ / _____ 2) _____ / _____
 Mumps vaccine 1) _____ / _____
 Rubella vaccine 1) _____ / _____
3. Antibody titers: **Measles:** Date _____ titer results _____
Mumps: Date _____ titer results _____ **Rubella:** Date _____ titer results _____

The following immunization are not required for enrollment, but are highly recommended				
Tetanus/Diphtheria	Initial date:	Booster:	Booster:	Booster:
Polio	Initial date:	Booster:	Booster:	Booster:
Hepatitis B	Initial date:	Booster:	Booster:	Booster:
Hepatitis A	Initial date:	Booster:	Booster:	Booster:
Varicella	Initial date:	Booster:	Booster:	Booster:
Meningococcal	Initial date:	Booster:	Booster:	Booster:

* Acceptable proof of immunization and/or disease history must be one or more of the following:

1. Completion of this section of the form, by a health care provider, with the provider's name, address, phone number and signature in the spaces below.
2. A copy of a school or public health immunization record or
3. A copy of a health care provider's record.

 Name of Physician/Clinician Signature

 Address City State Zip code