



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: \_\_\_\_\_ SSN: \_\_\_\_\_  
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 Hawaii 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: \_\_\_\_\_ SSN/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)

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 \_\_\_\_\_

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

\_\_\_\_\_  
 Address City State Zip code