EAST-WEST CENTER

ADMINISTRATIVE SUPPORT SERVICES

EWC HOUSING HEALTH CLEARANCE FORM

Health Clearance Forms are used by the East-West Center to establish and maintain conditions for a safe and healthy environment. Your compliance in completing these forms will help assure that the Center remains safe and healthy for all.

- A completed Housing Health Clearance Form is required of all guests staying more than 30 days.
- Note the sections below must be completed and signed by a health professional.
- **This form will be rejected if not fully completed/signed, in required sections, by a U.S. licensed practitioner.**

NAME: ____ ____/____/____

PRINT* Last Name, First Name, Middle Initial (per legal ID)** ***Date of Birth

"By my signature below, I declare that the information on this form is true and complete to the best of my knowledge and attest that I am in sufficiently good health and condition to reside in the East-West Center residence halls."

____ ____/____/____

Guest Signature ***Date***

EWC Housing Dates: ____/____/____ through ____/____/____

Check-In Date ***Check-Out Date***

Please list any conditions and/or special needs you have which you think may affect you while residing in East-West Center housing:

TUBERCULOSIS (TB) CLEARANCE

Skin tests from abroad are not accepted. Tuberculin (TB) skin test results must be submitted within two weeks of arrival at the East-West Center. A negative TB skin test administered in the United States up to one year prior to arrival is acceptable. If the TB test is positive, a follow-up chest x-ray is required. A University of Hawaii Health Services Medical Certificate is also acceptable.

I have evaluated the individual named above using the process set out in the State of Hawaiʻi DOH TB Clearance Manual and detremined that the individual does not have TB disease as defined in Section 11-164.2-2, Hawaiʻi Administrative Rules.

TB Screening Date: ____/____/____

☐ Negative TB risk assessment
☐ Negative Test for TB infection
☐ Positive test for TB infection & negative chest x-ray.

This TB clearance provides a reasonable assurance that the individual was free from tuberculosis disease at the time of the exam. This does not imply any guarantee or protection from future tuberculosis risk.

____ ______________________________

Signature or Stamp of Practitioner ***Date***

____ ______________________________

PRINT* name of Practitioner** ***Healthcare Facility

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IMMUNIZATION

Immunizations shall include the complete date the vaccine was administered, recorded as month/day/year. All immunizations must meet minimum ages and minimum intervals between doses. For Medical Exemption, see a U.S. licensed practitioner.

MMR (Measles, Mumps, Rubella) | 2 doses:

_____/_____/_____ ***Dose 1 Date***

_____/_____/_____ ***Dose 2 Date***

☐ Born before 1957 (exempt from MMR)

Varicella (chickenpox) | 2 doses:

_____/_____/_____ ***Dose 1 Date***

_____/_____/_____ ***Dose 2 Date***

☐ Born before 1980 (exempt from Varicella)

Tdap (Tetanus-diptheria-acellular pertussis) | 1 dose:

_____/_____/_____ ***Dose Date***

______________________________ ***Signature or Stamp of Practitioner***

______________________________ ***Date***

______________________________ ***PRINT name of Practitioner***

______________________________ ***Healthcare Facility***

COMPLETE ONLY IF GUEST WILL BE LIVING IN EWC HOUSING

☐ Yes ☐ No Residing in EWC housing?
☐ Yes ☐ No First-year student age 21 years or younger?

If Yes to both, please provide Meningococcal Conjugate (MCV) immunization date (at least 1 dose, on or after the age of 16 years):

Dose date: _____/_____/_____

______________________________ ***Signature or Stamp of Practitioner***

______________________________ ***Date***

______________________________ ***PRINT name of Practitioner***

______________________________ ***Healthcare Facility***