‘Iolani School Health Requirements

TO BE COMPLETED BY:
NON-HAWAII RESIDENTS (International & U.S. Mainland residents)

A. Tuberculosis examination requirements:
   1. The following are acceptable for clearance:
      a. Negative Mantoux skin test (less than 10 mm) within 12 months of school attendance
      b. Positive Mantoux skin test (l0 mm or greater) and a negative chest x-ray

B. Immunization requirements
   1. The following are required:
      a. DTaP, DPT 5 doses
      b. TD – 1 dose, 5-10 years after last required DPT or DTaP
      c. Polio (IPV or OPV) – 4 doses
      d. MMR – 2 doses
      e. Hepatitis B – 3 doses
      f. Varicella – 1-2 doses
   2. Laboratory evidence of immunity may be substituted.
   3. Documented history of Varicella by a practitioner may be substituted.
   4. Age and spacing of immunizations are as required by Title 11, Chapter 157 – Hawaii Administrative Rules

C. Only ‘Iolani School forms will be accepted.

D. The required health information must be performed, documented, and signed by a U.S. licensed practitioner (MD, DO, APRN or PA).

E. Exemptions and exceptions to these requirements will be evaluated as per the rules set forth in Title 11, Chapter 157, Hawaii Administrative Rules.

F. These requirements are in compliance with Hawaii State Law.

G. **This health form should accompany registration forms. Course registration will not be processed if this health form is not submitted.**

If you have any questions, please contact: School Nurse
‘Iolani School
(808) 943-2249, nurse@iolani.org

‘Iolani Summer School Health Form

TO BE COMPLETED BY: NON-HAWAII RESIDENTS (International & US Mainland residents)

Student's Name ________________________________ Nickname (AKA): ______________ Date of Birth: __________
Last First M.I.

TO BE COMPLETED BY A U.S. LICENSED PRACTITIONER (MD, DO, PA or APRN)

Practitioner’s name: ______________________________ U.S. License Number: ____________________________

Immunization Record – Required *

DTP, DTaP, DT or Td *		Polio: OPV or IPV *		MMR *	Hepatitis B *	Hepatitis A	Other
Type	**Date**	**Type**	**Date**	**Date**	**Date**	**Date**	
				Meningitis Vaccine	**Varicella Vaccine date(s) *:** 1. 2.		
				Date	**Immunity secondary to illness**		
					Date of illness: ____________________		
					Practitioner’s signature: ______________________________		

Tuberculosis Examination – Required *

Intradermal	Date given	Date Read	Results (mm)	Practitioner
Chest x-ray	**Date**	**Results**	**Location**	**Practitioner**

Grade ______

Height:________Weight:________B/P:__________

Eyes		Mouth/ Throat		Lungs		Neuro-logical		Extremities		Genital/ Rectal		Vision Right		Hearing Right	
Ears/Nose		Heart		Abdomen		Skin		Scoliosis/ Back prob.		Nutrition		Left		Left	

Examination code: N=Normal R=Receiving Care

Significant medical history: ____

____

Allergies: ____

Medications: Daily: ______________________________ PRN: ______________________________

Restrictions/Limitations: ____

School recreational participation (circle one): Yes with no restrictions Yes with the following restrictions:

____

No for the following reasons: ____

PHYSICIAN: I hereby certify that I have on this date, examined this student and reviewed the immunization record.

Signature of examining practitioner: ______________________________

Physician’s name and address - please print or stamp

Date: