International Students
'Iolani Summer Day Programs Health Requirements

Students who attend school outside the United States during the regular school year must complete the following:

**FIRST-TIME ENROLLMENT**

Only the 'Iolani Summer Day Programs Health Form will be accepted. All information must be completed in English by a U.S. licensed physician. The form includes the following sections for the U.S. licensed physician to complete in its entirety and sign:

1. Immunization Record - child must meet [Hawaii Administrative Rules for Immunizations](#):
   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
      i. Laboratory evidence of immunity may be substituted
      ii. Documented history of Varicella by a physician may be substituted
   g. Age and spacing of immunizations are as required by Title 11, Chapter 157

2. TB clearance via negative TB skin testing, chest x-ray or Quantiferon Gold blood test - completed and signed off by a US licensed physician, completed within 6 months of Summer Program start date

3. Physical Examination

**PREVIOUSLY ENROLLED** in 'Iolani Summer Programs during 2018 or 2019

1. Any previously enrolled student with outstanding immunizations must provide documentation by a U.S. licensed physician that the immunizations have been completed

2. TB clearance via negative TB skin testing, chest x-ray or Quantiferon Gold blood test. These can be completed by the student’s regular physician (non-US licensed). For Quantiferon Gold blood test, the laboratory results must be submitted signed off by the student’s physician indicating that they have reviewed these results and the student is negative for TB, completed within 6 months of Summer Program start date

3. Parents are responsible for indicating on the registration form if the child has any health conditions, allergies or medications needed during the Summer Programs day

**PLEASE NOTE**

- Submit completed forms electronically beginning in February to spo@iolani.org (grades 7-12) or LSSummer@iolani.org (grades K-6)
- Allow up to 15 business days for review
- If approved, notification of the assigned registration date and time will be emailed
- **Do NOT register before this assigned registration date and time.** Registrations received prior to your child’s assigned date and time will be denied, the student will be dropped from any courses, and a refund, less a 3% credit card processing fee will be issued.
- Please refer to the online Handbook for additional information

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`Iolani Summer Day Programs Health Form

Student Last Name: ___________________________ Student First Name: ___________________________

Preferred Name (AKA): ___________________________ Date of Birth (MM/DD/YY): ___________________________

TO BE COMPLETED AND SIGNED OFF BY A U.S. LICENSED PHYSICIAN

Physician’s Name: ___________________________ U.S. License Number: ___________________________

U.S. State of Licensure: ___________________________

1. Immunization Record -- Required*

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Type</th>
<th>Date</th>
<th>Type</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP, DTap, DT or Td*</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Polio: OPV or IPV*</td>
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<tr>
<td>MMR*</td>
<td></td>
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<tr>
<td>Hepatitis B*</td>
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<tr>
<td>Hepatitis A*</td>
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<tr>
<td>HPV</td>
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</tr>
</tbody>
</table>

2. Tuberculosis Examination -- Required*

<table>
<thead>
<tr>
<th>Examination</th>
<th>Date given</th>
<th>Date Read</th>
<th>Results (mm)</th>
<th>Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intradermal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest x-ray</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Physical Examination --Required*

<table>
<thead>
<tr>
<th>Examination</th>
<th>Height:</th>
<th>Weight:</th>
<th>Blood Pressure:</th>
<th>Grade:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td>Mouth</td>
<td>Throat</td>
<td>Lungs</td>
<td>Neurological</td>
</tr>
<tr>
<td>Hears</td>
<td>Heart</td>
<td>Abdomen</td>
<td>Skin</td>
<td>Scoliosis</td>
</tr>
</tbody>
</table>

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: ________________________________________________________________

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

Signature of examining Physician: ___________________________ U.S. Licensed Physician’s name and address (Please print or stamp below)

Date: ___________________________