UNIVERSITY OF GUAM
UNIBETSEDÅT GUAHAN

UOG STUDENT ID #:_____

HEALTH CLEARANCE FORM

This information is treated confidentially and does not become a part of your academic records. All students and employees of the University of Guam are required to complete and submit the health clearance form with immunization records from your clinic. Please type or print answers in English using ***BLACK OR BLUE INK***.

STUDENT INFORMATION

ANY OTHER NAMES USED ON OTHER REQUIRED DOCUMENTS

NAME: _____ _____
Last(Family Name) First Middle — Last(Family Name) First Middle

MAILING ADDRESS: _____
Street / P.O. Box City State Zip Code

DATE OF BIRTH: ____/____/____ **GENDER:** F ☐ M ☐ **EMAIL ADDRESS:** _____

PHONE: (H)(____)_____ (CELL)(____)_____ (W)(____)_____
Area Code Area Code Area Code

PLEASE CHECK ONE:
NEW STUDENT: ☐
RE-ENTRY: ☐
GRADUATE SCHOOL: ☐

EXPECTED TERM OF ENROLLMENT:
Year:_____ Semester:_____

Previously enrolled at UOG/GCC: No ☐ Yes ☐
Year:_____ Semester:_____

IN CASE OF EMERGENCY NOTIFY: NAME: _____ **RELATIONSHIP:** _____

PHONE: (H)(____)_____ (CELL)(____)_____ (W)(____)_____
Area Code Area Code Area Code

EMAIL ADDRESS: _____

Note: Information regarding disability, voluntarily given or inadvertently received, will not adversely affect any admissions decision. If you should require special services because of your disability, you may notify the University Health Nurse or Enrollment Management and Student SdzÖÖŜää Dean. This voluntary self-identification allows the University of Guam to prepare appropriate support services to facilitate your learning. This information will be kept in strict confidence and has no effect on your admission to the University of Guam.

DO YOU HAVE ANY SIGNIFICANT MEDICAL CONDITIONS OR DISABILITIES THAT WOULD LIMIT PARTICIPATION IN ACADEMIC AND/OR PHYSICAL ACTIVITIES?

Please specify: _____

_____

Drug allergy: _____

_____

Other allergies: _____

_____

STUDENT SIGNATURE: _____ **DATE:** _____

URGENT DEADLINES TO SUBMIT HEALTH FORMS: **FALL SEMESTER: LAST FRIDAY OF JUNE**
SPRING SEMESTER: LAST FRIDAY OF NOVEMBER
SUMMER SEMESTER: LAST FRIDAY OF APRIL

PLEASE NOTE: IF FRIDAY FALLS ON A HOLIDAY, PLEASE SUBMIT YOUR FORMS ON THURSDAY

PLEASE DO NOT SEND YOUR MEDICAL FORMS THROUGH EMAIL.

Mail or fax form to:
University of Guam
Student Health Services
303 University Drive, Guam 96913
Tel: (671) 735-2225/6 Fax: (671) 734-4651
Email: uogstudenthealth@triton.uog.edu

revised 11/2016 JRG

UNIVERSITY OF GUAM
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STUDENT HEALTH SERVICES

*The University of Guam requires all newly entering students to be immunized against MEASLES and RUBELLA (GERMAN MEASLES). This medical requirement will be strictly monitored and enforced due to the increasing occurrence of measles in adults throughout the Pacific and United States. Under Guam Public Law Article 3, Chapter 3, §3322. Vaccination and Immunaztion, no student shall be permitted to attend school **unless** evidence is presented, indicating that the student is free from any communicable diseases, and has had all the required vaccinations or immunzations.* ***(Please use BLACK or BLUE ink)***

STUDENT'S NAME: _____
LAST FIRST MIDDLE

UOG ID#: _____ DATE OF BIRTH: _____

REQUIRED IMMUNIZATIONS – MEASLES/MUMPS/RUBELLA (MMR), PPD

To avoid unnecessary vaccination of MMR, please refer back to your old shot records first for two (2) doses of MMR. You may obtain a copy of your shot records from your clinic, elementary, middle, or high school, or previous college attended. Two (2) doses are required and must have be given at least 28 days apart for students born after 1956 (CDC). This requirement is to be waived if: 1) the student was born **on or before 1957** or 2) if a physician has documented the diagnosis of measles in the past or 3) Serologic evidence of immunity is provided. Complete one of the following:

Date of Last Immunization			or Antibody Titer Results:	Circle One
Measles (§)			Measles date and result: _____	Pos / Neg
Mumps (§)		**(§ BORN AFTER 1956)**	Mumps date and result: _____	Pos / Neg
Rubella (§)			Rubella date and result: _____	Pos / Neg

PPD Date Given _____ Date Read _____ Results(mm) _____ Clinic _____

Students must show valid documentation of TB skin test result conducted within six (6) months prior to entry into the University of Guam. ***NEGATIVE and four (4) day readings are NOT accepted.***

If PPD is positive (+): Obtain a Latent Tuberculosis Infection (LTBI) form and have it filled out by a physician. Attach Chest X-Ray Report (must be within 4 years) and proceed to Department of Public Health & Social Services in Mangilao, Tuberculosis Department to obtain your Public Health clearance. *Office Hours for Public Health (TB Dept.): Mon- Thurs: 8:00 AM - 5:00 PM | for more info: call 735-7157*

PART III – MENINGOCOCCAL, TETANUS/DIPHTHERIA/PERTUSSIS, AND VARICELLA (OPTIONAL)
Although not required for enrollment, these vaccines are recommended.

Varicella	Disease Date:	Titer date and result: +/-	Dose #1 and Dose #2 dates:
Tetanus, Diphtheria, Pertussis: One dose of Tdap for all students, regardless of interval since last Td booster	☐Td OR ☐Tdap Date of most recent dose:	Td primary series dates	
Meningococcal Quadrivalent vaccine date(s):		Hepatitis A and Hepatitis B:	Polio:
Dates of other vaccines highly recommended	Human Papilloma Virus Vaccine:		

- **Dates of immunizations must be indicated and signed by provider or immunization record submitted with Medical History Form.**
- **All corrections made, must be initialed by provider (NO-WHITE OUTS ACCEPTED).**

PLEASE DO NOT SEND YOUR MEDICAL FORMS THROUGH EMAIL.

Mail or fax form to:
University of Guam
Student Health Services
303 University Drive, Guam 96913
Tel: (671) 735-2225/6 Fax: (671) 734-4651
Email: uogstudenthealth@triton.uog.edu

_____
Name MD/Nurse (PRINT/STAMP/SIGN) Date

_____
Clinic/Address

Area Code( ) _____
Phone Number/Email

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LATENT TUBERCULOSIS INFECTION (LTBI) QUESTIONNAIRE

PLEASE SUBMIT FOR CLEARANCE REQUEST FOR PATIENTS HAVING POSITIVE TB SKIN TEST

NAME		**DOB** ____/____/____	
ADDRESS			
ETHNICITY		**PHONE NUMBERS: (HOME/WORK/MOBILE)**	

PPD SKIN TEST	Date given:	Date read:	Results: _____mm
Chest X-Ray (Copy of report **MUST** Be Attached)	Date of CXR exam:	☐ Normal ☐ Abnormal	Comments: _____ _____
LTBI Treatment	Date treatment started:	Date completed:	☐ No h/o treatment
	Adverse reactions to LTBI therapy? ☐ YES ☐ NO	Patient declined therapy? ☐ YES ☐ NO	

Have you been exposed to active TB? ☐ YES ☐ NO

SYMPTOMS	YES	NO
Cough		
Fever		
Weight loss		
Night sweats		
Fatigue		
Chest pain		
Shortness of breath		
Hoarseness		

If response is "yes" to any of the symptoms, patient will need a repeat 2 view CXR before referral to Public Health for clearance.

Please include findings from repeat CXR (Copy of report **MUST** be attached)**:**

☐ Normal

☐ Abnormal

Patient is cleared for work/school	☐ Yes	☐ No
Patient is referred to the Department of Public Health Communicable Disease Clinic for possible active tuberculosis **(All required documents MUST accompany referral)**.	☐ Yes	☐ No

Physician Signature/Stamp **Name of Physician/Clinic** **Date (Valid 90 days)**

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
BUREAU OF COMMUNICABLE DISEASE CONTROL
TUBERCULOSIS/HANSEN'S DISEASE CONTROL PROGRAM
123 Chalan Kareta, Mangilao, Guam 96913
671-735-7157/7131/7120/7145

Revised and effective: September 10, 2015