

MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION VERIFICATION

FORM D

Student Information

Last Name/Surname

First Name

Middle Initial

Date of Birth (mm/dd/yyyy)

HPU Student ID Number

This form has been completed to the best of my knowledge, and I freely consent to this information being used for my registration at Hawai'i Pacific University.

Student Signature

Date (MM/DD/YYYY)

MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

- A student born before 1957 is exempt from the MMR immunization requirement.
- Proof of two doses of the Measles vaccine is required, one of the vaccines should contain Measles, Mumps, and Rubella (MMR) and the second vaccine could be either the Measles, Mumps, and Rubella (MMR) or Measles only. At least ONE must be the MMR vaccine with the first dose on or after 12 months of age, and the second dose at least 4 weeks after the first dose; OR
- Positive MMR Titer Blood Test Report

The following clearance must be filled out and signed or stamped by a Medical Doctor (MD), Doctor of Osteopathy (DO), Nurse Practitioner (NP), Physician Assistant (PA) or clinic:

COMPLETE ONE OF THE FOLLOWING:

1. First Measles, Mumps, Rubella (MMR) Immunization

Month	Day	Year

Second Measles, Mumps, Rubella (MMR) Immunization

Month	Day	Year

OR 2. Measles, Mumps, Rubella (MMR) Immunization

Month	Day	Year

Measles (Rubeola) Vaccine

Month	Day	Year

OR 3. MMR Titer Blood Test Report (Titer lab results for Measles, Mumps and Rubella must be attached)

Month	Day	Year

Name of Physician/Healthcare Professional

Signature

Date

U.S. State & License Number

State

Zip Code

Hawaii Pacific University
1 Aloha Tower Drive | Honolulu, Hawai'i 96813
Phone: (808) 544-0238 | Fax: (808) 544-1136





TDAP, MENINGOCOCCAL (MCV), VARICELLA (VCV) IMMUNIZATION VERIFICATION

FORM E

Student Information

Last Name/Surname

First Name

Middle Initial

Date of Birth (mm/dd/yyyy)

HPU Student ID Number

This form has been completed to the best of my knowledge, and I freely consent to this information being used for my registration at Hawai'i Pacific University.

Student Signature

Date (MM/DD/YYYY)

The following is to be completed by a healthcare provider with immunization records attached. Form must be completed in its entirety.

TDAP

First TDAP Dose		
Month	Day	Year

VARICELLA (VCV)

COMPLETE ONE OF THE FOLLOWING:

First Varicella (VCV) Dose		
Month	Day	Year

Second Varicella (VCV) Dose		
Month	Day	Year

OR

Varicella (VCV) Titer (attach blood test results)		
Month	Day	Year

Immune NOT Immune

LIVING ON CAMPUS ONLY

Required for new students planning to live on-campus who are 21 years of age or younger.

MENINGOCOCCAL (MCV)

First Meningococcal (MCV) Dose		
Month	Day	Year

Name of Physician/Healthcare Professional

Signature

Date

U.S. State & License Number

State

Zip Code

Hawaii Pacific University

1 Aloha Tower Drive | Honolulu, Hawai'i 96813
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Students need: One dose of Tetanus-Diphtheria-Acellular Pertussis (TDAP). Two doses of Varicella (VCV) separated by at least one month or a Varicella (VCV) Titer with blood test results attached are required. *If the student plans to live on-campus in the dormitories, one dose of Meningococcal (MCV) is also required.*

04/23/2020 DB