



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 US licensed practitioner/healthcare provider. Form must be completed in its entirety.

TDAP

Most Recent TDAP Dose		
Month	Day	Year

VARICELLA (VCV)

COMPLETE THE FOLLOWING:

First Varicella (VCV) Dose		
Month	Day	Year
Second Varicella (VCV) Dose		
Month	Day	Year

Varicella Exemptions:

- Students born in the United States prior to 1980. (Must attach proof of date of birth to this form).
- A signed, documented diagnosis or verification of a history of varicella disease or herpes zoster by a practitioner. (Must attach verification to this form. Practitioners may use this form for verification).

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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08/30/2020 DB