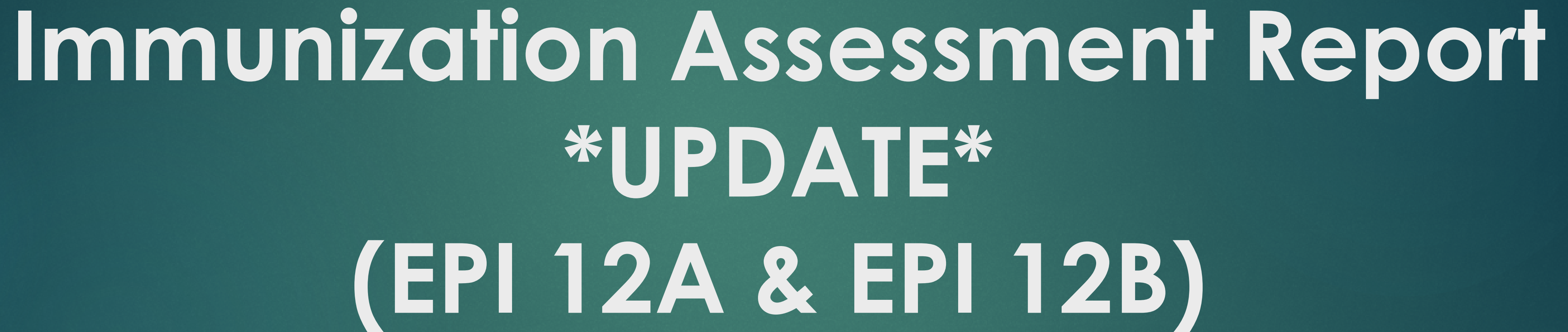

STATE OF HAWAII
DEPARTMENT OF HEALTH
IMMUNIZATION BRANCH

Responsibility

- Each school and child care facility principal or administrator shall ensure that his or her school or facility only admits students or children who comply with the health requirements for school attendance.

Hawaii Administrative Rules §11-157-3.1

Responsibility

- Each school and child care facility must report to the Department of Health all students and children who:
  - Have been provisionally admitted
    - Report must include the types of immunizations and dose numbers which are incomplete for each student
  - Have been excluded for failure to comply with the immunization or examination requirements
  - Have medical or religious exemptions

Responsibility

- Each school and child care facility are required to submit the report even if all students or children have met the immunization and examination requirements.
- The report must be in a format specified by the Department of Health (DOH):
  - Immunization Assessment Report (EPI 12A and EPI 12B)

Immunization Assessment Report (EPI 12A & EPI 12B)

- All schools must submit an Immunization Assessment Report (EPI 12A &/or EPI 12B to DOH biannually by October 10th and January 10th of each school year
  - Reporting is required even if all students meet the health requirements
  - The second report (due January 10th) is required even if all students met the health requirements on the October 10th report
- The report lists the students:
  - Who have not met the immunization and examination requirements and have been provisionally admitted
  - Who have a medical or religious exemption
- EPI 12A is for **childcare centers, preschools, and head start programs**
- EPI 12B is for public and private schools with **grades K-12**

Purpose of EPI 12A & EPI 12B

- Identify and track students who have not met the immunization and physical examination requirements
- Evaluate public health risk for vaccine-preventable outbreaks

EPI 12A Form *2020*- Preschools

HAWAII STATE DEPARTMENT OF HEALTH

IMMUNIZATION ASSESSMENT REPORT FOR HAWAII CHILD CARE FACILITIES

SECTION 1:
SCHOOL ID
SCHOOL NAME
ADDRESS

PHONE
FAX
EMAIL

SECTION 2:
TOTAL ENROLLMENT (Preschool students only)
PREPARED BY
TITLE
DATE

DO ALL STUDENTS MEET THE IMMUNIZATION AND EXAMINATION REQUIREMENTS ? YES ☐ NO ☐

IF YES, PLEASE SIGN THIS FORM BELOW
IF NO, PLEASE COMPLETE SECTION 3 BELOW AND SIGN THIS FORM

SECTION 3:

MARK MISSING IMMUNIZATIONS AND MISSING PE (PHYSICAL EXAM) WITH AN X

STUDENT INFORMATION				SELECT ONE ONLY			MISSING IMMUNIZATIONS																						PE
					EXEMPT																								
Last Name	First Name	Date of Birth	Entry Date	No Record	Religious	Medical	DTAP				POLIO			Hib				PCV				HEP B			HEP A		MMR	VAR	
							1	2	3	4	1	2	3	1	2	3	4	1	2	3	4	1	2	3	1	2	1	1	

EPI 12A 6/20

PRINCIPAL/DIRECTOR'S SIGNATURE ____________________

EPI 12B Form- Kindergarten to 12th

HAWAII STATE DEPARTMENT OF HEALTH

IMMUNIZATION ASSESSMENT REPORT FOR HAWAII SCHOOLS K-12

SECTION 1: SCHOOL ID
SCHOOL NAME
ADDRESS

PHONE
FAX
EMAIL

SECTION 2: TOTAL ENROLLMENT — K-12 ONLY. DO NOT INCLUDE PRESCHOOL STUDENTS
Kindergarten only
7th Grade only

PREPARED BY
TITLE
DATE

DO ALL STUDENTS MEET THE IMMUNIZATION AND EXAMINATION REQUIREMENTS ? YES ☐ NO ☐
IF YES, PLEASE SIGN THIS FORM BELOW
IF NO, PLEASE COMPLETE SECTION 3 BELOW AND SIGN THIS FORM

SECTION 3: MARK MISSING IMMUNIZATIONS AND MISSING PE (PHYSICAL EXAM) WITH AN X

STUDENT INFORMATION					SELECT ONE ONLY			MISSING IMMUNIZATIONS																							PE
						EXEMPT		DTAP					POLIO				HEP B			HEP A		MMR		VAR		Tdap	MCV	HPV			
Last Name	First Name	Date of Birth	Entry Date	Grade	No Record	Religious	Medical	1	2	3	4	5	1	2	3	4	1	2	3	1	2	1	2	1	2	1	1	1	2	3	

PRINCIPAL/DIRECTOR'S SIGNATURE ______________________

EPI 12B 6/20

EPI 12A & EPI 12B Forms

- EPI 12A and EPI 12B forms are available electronically on the Department of Health website at: https://health.hawaii.gov/docd/resources/reports/school-assessment-reports/
- Completion of the electronic form is **STRONGLY ENCOURAGED**
  - Ability to save data from the first report will assist the schools in completing the second report, due on January 10th
- Electronic EPI 12A and EPI 12B forms may be sent via **SECURE EMAIL** to: doh.schoolreports@doh.hawaii.gov

Completing the Immunization Assessment Report

IMMUNIZATION ASSESSMENT REPORT FOR HAWAII SCHOOLS K-12

SECTION 1:

SCHOOL ID	100
SCHOOL NAME	Kulea a Elementary and Middle School
ADDRESS	111 P nchbowl Street
	Honolul HI 96813
PHONE	(808) 586- 000
FAX	(808) 586-9 99
EMAIL	sha@kuleana.k12.h us

SECTION 2:

TOTAL ENROLLMENT	500	K-12 ONLY. DO NOT INCLUDE PRESCHOOL STUDENTS
Kindergarten only	50	
7th Grade only	75	

PREPARED BY	Hawaii Fiveo
TITLE	SHA
DATE	10/1/2020

DO ALL STUDENTS MEET THE IMMUNIZATION AND EXAMINATION REQUIREMENTS ? YES ☐ NO ☐

IF YES, PLEASE SIGN THIS FORM BELOW
IF NO, PLEASE COMPLETE SECTION 3 BELOW AND SIGN THIS FORM

ID number

Enrollment

Provisional Entrance (10B) and Notice of Exclusion (10D)

School: Kuleana Elementary & Middle School Date: August 7, 2020

PROVISIONAL ENTRANCE NOTICE

To the Parent/Guardian of: Amy Immunosaurus Birth Date: 5/1/15 Grade K

Your child has been allowed to enter school on 8/7/20 on a provisional (temporary) status. According to our records, your child is missing the following requirements.

☑ **IMMUNIZATIONS**

		Missing Dose	Dose does not meet minimum age/interval requirements
DTaP	[Dose Number(s) 5]	☑	☐
Polio	[Dose Number(s) 4]	☑	☐
Hib (Preschool only)	[Dose Number(s) ____]	☐	☐
PCV (Preschool only)	[Dose Number(s) ____]	☐	☐
Hepatitis B	[Dose Number(s) ____]	☐	☐
Hepatitis A	[Dose Number(s) ____]	☐	☐
MMR	[Dose Number(s) 2]	☑	☐
Varicella*	[Dose Number(s) ____]	☐	☐
HPV (7th grade only)	[Dose Number(s) ____]	☐	☐
MCV (7th grade only)	[Dose Number(s) ____]	☐	☐
Tdap (7th grade only)	[Dose Number(s) ____]	☐	☐

*A documented history of varicella (chickenpox) disease, signed by a U.S. licensed physician, advanced practice registered nurse, or physician's assistant may be substituted for the varicella vaccine requirement.

☐ **PHYSICAL EXAMINATION**
Performed by a U.S. licensed physician, advanced practice registered nurse, or physician's assistant within 12 months prior to the date of preschool or school entry.

Certification that the above requirements have been completed must be submitted to the schools NO LATER THAN Nov. 7, 2020. If certification is not received by this date, your child will be excluded from school.

NOTE: Provisional entrance may be suspended when there is a danger of an epidemic from any communicable disease for which immunization is required. Your child will not be permitted to attend school unless he/she receives the required immunization or until the epidemic is over.

If you have any questions, please call the school health aide at (808) 987-6543

Principal

EPI 10B 06/20

School: Kuleana Elementary & Middle School Date: November 7, 2020

NOTICE OF EXCLUSION

To the Parent/Guardian of: Amy Immunosaurus Birth Date: 5/1/15 Grade K

School health laws require that students receive a physical examination and immunizations before entering/attending preschool or school in Hawaii.

According to our records, your child is still missing the following requirements:

☑ **IMMUNIZATIONS**

		Missing Dose	Dose does not meet minimum age/interval requirements
DTaP	[Dose Number(s) 5]	☑	☐
Polio	[Dose Number(s) 4]	☑	☐
Hib (Preschool only)	[Dose Number(s) ____]	☐	☐
PCV (Preschool only)	[Dose Number(s) ____]	☐	☐
Hepatitis B	[Dose Number(s) ____]	☐	☐
Hepatitis A	[Dose Number(s) ____]	☐	☐
MMR	[Dose Number(s) 2]	☑	☐
Varicella*	[Dose Number(s) ____]	☐	☐
HPV (7th grade only)	[Dose Number(s) ____]	☐	☐
MCV (7th grade only)	[Dose Number(s) ____]	☐	☐
Tdap (7th grade only)	[Dose Number(s) ____]	☐	☐

*A documented history of varicella (chickenpox) disease, signed by a U.S. licensed physician, advanced practice registered nurse, or physician's assistant may be substituted for the varicella vaccine requirement.

☐ **PHYSICAL EXAMINATION**
Performed by a U.S. licensed physician, advanced practice registered nurse, or physician's assistant within 12 months prior to the date of school entry.

Your child provisionally entered school on 8/7/20 and has been allowed three months to complete the above requirements. The school has not received certification that these health requirements have been met.

Please arrange with your child's doctor to complete these requirements as soon as possible and provide the school with certification of their fulfillment. **If these requirements are not completed, your child will be denied further attendance at school on** 12/7/20 **(Hawaii Administrative Rules 302A-1162).**

If you have any questions or difficulty meeting these requirements, please call the school health aide at 987-6543

Principal

EPI 10D 06/20

Completing the EPI 12 B: Missing Immunization(s)

SECTION 3: MARK MISSING IMMUNIZATIONS AND MISSING PE (PHYSICAL EXAM) WITH AN X

STUDENT INFORMATION					SELECT ONE ONLY			MISSING IMMUNIZATIONS																									PE
						EXEMPT		DTAP					POLIO				HEP B			HEP A		MMR		VAR		Tdap	MCV	HPV			
Last Name	First Name	Date of Birth	Entry Date	Grade	No Record	Religious	Medical	1	2	3	4	5	1	2	3	4	1	2	3	1	2	1	2	1	2	1	1	1	2	3	
Immunosaurus	Amy	5/1/2015	8/7/2020	K								X				X							X								
Waikiki	Johnny	7/11/2010	8/7/2020	5			X																	X	X						
Mililani	Leilani	1/23/2014	8/5/2019	1		X																									
Makaha	Mele	4/19/2015	8/7/2020	K	X																										
Aloha	Maile	5/10/2008	8/4/2020	7																											X

IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)							
DTaP, DTP, DT, Tdap or Td	Type	DTaP	DTaP	DTaP	DTaP		
	Date	07/15/14	09/01/14	11/15/14	08/15/15	/ /	/ /
Polio (IPV or OPV)	Type	IPV	IPV	IPV			
	Date	07/15/14	09/01/14	08/15/15	/ /	/ /	/ /
Hib (*Haemophilus influenzae* type b)	Type	Hib	Hib	Hib	Hib		
	Date	07/15/14	09/01/14	11/15/14	08/15/15	/ /	/ /
Pneumococcal Conjugate	Type	PCV13	PCV13	PCV13	PCV13		
	Date	07/15/14	09/01/14	11/15/14	08/15/15	/ /	/ /
Hepatitis B	Type	Hep B	Hep B	Hep B			
	Date	05/01/14	07/15/14	11/15/14	/ /	/ /	/ /
Hepatitis A	Type	Hep A	Hep A				
	Date	08/15/15	03/15/16	/ /	/ /	/ /	/ /
MMR	Type	MMR			Varicella	Varicella	
	Date	08/15/15	/ /	/ /	Date	08/15/15	/ /
HPV	Type				Meningococcal Conjugate		
	Date	/ /	/ /	/ /	Date	/ /	/ /
Other	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /

Medical Exemption Sample

Medical Exemption Form

Instructions for completing Medical Exemption Form:
Section 1: Completed by parent/guardian or student (aged ≥18 years): Enter child care facility, school, or post-secondary school, and student information
Section 2: Completed by licensed health care provider (MD, DO, ND, APRN-Rx, PA): Check exempted vaccine, contraindication or precaution, or both, and complete duration of exemption

Section 1: Child Care Facility, School, Post-Secondary School, and Student Information

Student's Name:	Student's Date of Birth:		
Student's Home Address	City	State	Zip
Name of Child Care Facility, School, Post-Secondary School	Street Address	City	Zip

I understand that if at any time there is, in the opinion of the Department of Health, danger of an outbreak or epidemic from any communicable disease for which immunization is required, this exemption from immunization shall not be recognized and the student named above will be excluded from attending the child care facility, school, or post-secondary school until the Director of Health has determined that the presence of the outbreak no longer exists [HRS §302A-1157].

Parent/Guardian Name [if student <18 years]. (Please print): ____________________

Parent/Guardian OR Student (if aged ≥18 years) Signature: ____________________ Date: __________

Section 2: For Health Care Provider Use ONLY (MD, DO, ND, APRN-Rx, PA):

VACCINE	CONTRAINDICATIONS* (Check all that apply to this patient):	PRECAUTIONS* (Check all that apply to this patient)	FROM:	TO:
☐ DTaP ☐ Tdap ☐ DT, Td	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ **DTaP/Tdap only:** Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures), not attributable to another identifiable cause, within 7 days of administration of previous dose of DTP, DTaP, Tdap	☐ Guillain-Barre Syndrome <6 weeks after previous dose of tetanus-toxoid-containing vaccine ☐ History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid-containing or tetanus-toxoid-containing vaccine ☐ Moderate or severe acute illness with or without fever ☐ **DTaP/Tdap only:** Progressive or unstable neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy	/ /	/ /
☐ Hib	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Age <6 weeks	☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ Hep A	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ Hep B	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Hypersensitivity to yeast	☐ Moderate or severe acute illness with or without fever	/ /	/ /

*https://health.hawaii.gov/docd/files/2019/08/HAR11-157_EXHIBIT_B.pdf

Student's Name: ____________________ Student's Date of Birth: __________

Section 2: For Health Care Provider Use ONLY (MD, DO, ND, APRN-Rx, PA):

VACCINE	CONTRAINDICATIONS* (Check all that apply to this Patient):	PRECAUTIONS* (Check all that apply to this patient)	FROM:	TO:
☐ HPV	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	☐ Pregnancy ☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ MMR	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Pregnancy ☐ Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) ☐ Family history of altered immunocompetence	☐ Recent (<11 months) receipt of antibody-containing blood product ☐ History of thrombocytopenia or thrombocytopenic purpura ☐ Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing ☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ MCV	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ PCV	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose of PCV13 or any diphtheria-toxoid-containing vaccine or to a component of a vaccine (PCV13 or any diphtheria-toxoid-containing vaccine)	☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ IPV	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	☐ Pregnancy ☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ Varicella	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) ☐ Pregnancy ☐ Family history of altered immunocompetence	☐ Recent (<11 months) receipt of antibody-containing blood product ☐ Moderate or severe acute illness with or without fever ☐ Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination ☐ Use of aspirin or aspirin-containing products	/ /	/ /

I certify that in my medical judgement, due to the contraindication(s)/precaution(s) noted above, this student is exempt from the specific vaccine(s) named for the period indicated.

Health care provider's name/Title (Please Print): ____________________ License number: __________

Address: ____________________

Health care provider's signature: ____________________ Date: __________

Give completed original form to parent/guardian or student (aged ≥18 years). Send COPY of form to: State of Hawaii Department of Health, Immunization Branch, P.O. Box 3378, Honolulu, HI 96801 OR Fax to (808) 586-8347.

DTaP=Diphtheria, Tetanus, acellular Pertussis, Tdap=Tetanus, diphtheria, acellular pertussis, DT=diphtheria, tetanus, Td=tetanus, diphtheria, Hib=*Haemophilus influenzae* type B, Hep A=hepatitis A, Hep B=hepatitis B, HPV=human papillomavirus, MMR=measles, mumps, rubella, MCV=meningococcal conjugate vaccine, PCV=pneumococcal conjugate vaccine, IPV=inactivated poliovirus vaccine

Completing the EPI 12B: Medical Exemption

SECTION 3:

MARK MISSING IMMUNIZATIONS AND MISSING PE (PHYSICAL EXAM) WITH AN X

STUDENT INFORMATION					SELECT ONE ONLY			MISSING IMMUNIZATIONS																							PE
Last Name	First Name	Date of Birth	Entry Date	Grade	No Record	EXEMPT		DTAP					POLIO				HEP B			HEP A		MMR		VAR		Tdap	MCV	HPV			
						Religious	Medical	1	2	3	4	5	1	2	3	4	1	2	3	1	2	1	2	1	2	1	1	1	2	3	
Immunosaurus	Amy	5/1/2015	8/7/2020	K								X				X							X								
Waikiki	Johnny	7/11/2010	8/7/2020	5			X																	X	X						
Mililani	Leilani	1/23/2014	8/5/2019	1		X																									
Makaha	Mele	4/19/2015	8/7/2020	K	X																										
Aloha	Maile	5/10/2008	8/4/2020	7																											X

Religious Exemption

REQUEST FOR EXEMPTION FROM VACCINATION ON RELIGIOUS GROUNDS

Student's Name:		Student's Date of Birth:	
Student's Home Address:		City	Zip
Name of Child Care Facility or School:	Street Address:	City	Zip

______ Initials — I certify that immunization conflicts with my bona fide religious tenets and practices.

______ Initials — I understand that if at any time there is, in the opinion of the Department of Health, danger of an outbreak or epidemic from any communicable disease for which immunization is required, this exemption from immunization shall not be recognized and my child will be excluded from school or his/her child care facility until the threat of an epidemic is over or he/she receives the proper immunization.

______ Initials — I understand that a request for religious exemption based on objections to specific vaccines will not be granted.

I understand the benefits and risks of the vaccinations my child is required to have for school/child care facility attendance, the risk of my child contracting the diseases that vaccines prevent, and the risk of my child transmitting disease to others. I understand that this form may not be used for personal or philosophical reasons.

____
Parent/Guardian Name (please print)

____ Date: ______________
Parent/Guardian Signature

HAWAII REVISED STATUTES: §302A-1156, §302A-1157, §325-34
HAWAII ADMINISTRATIVE RULES: §11-157-5

State of Hawaii Department of Health
Epi 7A September 2019

Completing the EPI 12B: Religious Exemption

SECTION 3:

MARK MISSING IMMUNIZATIONS AND MISSING PE (PHYSICAL EXAM) WITH AN X

STUDENT INFORMATION					SELECT ONE ONLY			MISSING IMMUNIZATIONS																							PE
						EXEMPT																									
Last Name	First Name	Date of Birth	Entry Date	Grade	No Record	Religious	Medical	DTAP					POLIO				HEP B			HEP A		MMR		VAR		Tdap	MCV	HPV			
								1	2	3	4	5	1	2	3	4	1	2	3	1	2	1	2	1	2	1	1	1	2	3	
Immunosaurus	Amy	5/1/2015	8/7/2020	K								X				X							X								
Waikiki	Johnny	7/11/2010	8/7/2020	5			X																	X	X						
Mililani	Leilani	1/23/2014	8/5/2019	1		X																									
Makaha	Mele	4/19/2015	8/7/2020	K	X																										
Aloha	Maile	5/10/2008	8/4/2020	7																											X

Completing the EPI 12B: No Record

SECTION 3: MARK MISSING IMMUNIZATIONS AND MISSING PE (PHYSICAL EXAM) WITH AN X

STUDENT INFORMATION					SELECT ONE ONLY			MISSING IMMUNIZATIONS																							PE
Last Name	First Name	Date of Birth	Entry Date	Grade	No Record	EXEMPT		DTAP					POLIO				HEP B			HEP A		MMR		VAR		Tdap	MCV	HPV			
						Religious	Medical	1	2	3	4	5	1	2	3	4	1	2	3	1	2	1	2	1	2	1	1	1	2	3	
Immunosaurus	Amy	5/1/2015	8/7/2020	K								X				X							X								
Waikiki	Johnny	7/11/2010	8/7/2020	5			X																	X	X						
Mililani	Leilani	1/23/2014	8/5/2019	1		X																									
Makaha	Mele	4/19/2015	8/7/2020	K	X																										
Aloha	Maile	5/10/2008	8/4/2020	7																											X

Completing the EPI 12B: Missing Physical Examination

SECTION 3: **MARK MISSING IMMUNIZATIONS AND MISSING PE (PHYSICAL EXAM) WITH AN X**

STUDENT INFORMATION					SELECT ONE ONLY			MISSING IMMUNIZATIONS																							
Last Name	First Name	Date of Birth	Entry Date	Grade	No Record	EXEMPT		DTAP					POLIO				HEP B			HEP A		MMR		VAR		Tdap	MCV	HPV			PE
						Religious	Medical	1	2	3	4	5	1	2	3	4	1	2	3	1	2	1	2	1	2	1	1	1	2	3	
Immunosaurus	Amy	5/1/2015	8/7/2020	K								X				X							X								
Waikiki	Johnny	7/11/2010	8/7/2020	5			X																	X	X						
Mililani	Leilani	1/23/2014	8/5/2019	1		X																									
Makaha	Mele	4/19/2015	8/7/2020	K	X																										
Aloha	Maile	5/10/2008	8/4/2020	7																											X

Summary

- Record the ID number for your school/program

  The ID numbers are available:

  - Online on the DOH website https://health.hawaii.gov/docd/resources/reports/school-assessment-reports/ or
  - Contact the Immunization Branch at 586-8300 for assistance.

- Students who have not met the PE or immunization requirements may be allowed provisional attendance upon submitting written documentation from a practitioner that the student is in the process of completing the requirements. School should send parent/guardian the **EPI 10B form (Provisional Entrance Notice) or the EPI 10C form (for 7th graders)**.

- A student who does not complete all of the requirements by the end of the provisional entry period should be issued a Notice of Exclusion (**EPI 10D form**)

- Students listed on the EPI 12 form in October because of missing requirements should NOT appear on the EPI 12 form in January because they should have either:
  - Completed all missing requirements OR
  - Been excluded from school

Reporting Information

Forms may be sent to:
STATE OF HAWAII DEPARTMENT OF HEALTH
HI IMMUNIZATION PROGRAM
P. O. BOX 3378
Honolulu, HI 96801
Or
FAX: (808) 586-7511
Or
via **Secure Email** to
doh.schoolreports@doh.hawaii.gov

Call (808) 586-8300 for questions