Meningococcal Disease
New York State Department of Health Bureau of Communicable Disease Control

Information for College Students and Parents of Children at Residential Schools and Overnight Camps

What is meningococcal disease?
- Meningococcal disease is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord).

Who gets meningococcal disease?
- Anyone can get meningococcal disease, but it is more common in infants and children. For some college students, such as freshmen living in dormitories, there is an increased risk of meningococcal disease. Between 100 and 125 cases of meningococcal disease occur on college campuses every year in the United States; between 5 and 15 college students die each year as result of infection. Currently, no data are available regarding whether children at overnight camps or residential schools are at the same increased risk for disease. However, these children can be in settings similar to college freshmen living in dormitories. Other persons at increased risk include household contacts of a person known to have had this disease, immunocompromised people, and people traveling to parts of the world where meningitis is prevalent.

How is the germ meningococcus spread?
- The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person. Many people carry this particular germ in their nose and throat without any signs of illness, while others may develop serious symptoms.

What are the symptoms?
- High fever, headache, vomit, stiff neck and a rash are symptoms of meningococcal disease. Among people who develop meningococcal disease, 10-15% die, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur.

How soon do the symptoms appear?
- The symptoms may appear 2 to 10 days after exposure, but usually within 5 days.

What is the treatment for meningococcal disease?
- Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease.

Is there a vaccine to prevent meningococcal meningitis?
- Yes, a safe and effective vaccine is available. The vaccine is 85% to 100% effective in preventing four kinds of bacteria (serogroups A, C, Y, W-135) that cause about 70% of the disease in the United States.

Is the vaccine safe? Are there adverse side effects to the vaccine?
- The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days.

What is the duration of protection from the vaccine?
- After vaccination, immunity develops within 7 to 10 days and remains effective for approximately 3 to 5 years. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals.

How do I get more information about meningococcal disease and vaccination?
- Contact your family physician or your student health service. Additional information is also available on the websites of the New York State Department of Health, www.health.state.ny.us; the Centers for Disease Control and Prevention www.cdc.gov/ncid/dbmd/diseaseinfo; and the American College Health Association, www.acha.org.
Name: ___________________________ DOB: ___________ PAGE 2 OF 2

MMR (measles, mumps, rubella)

New York State Law requires all college students to have MMR vaccine documentation or waiver. Please indicate which one the following you will submit with your health form:

☐ Proof of two MMR immunizations (record from school or doctor's office)
☐ MMR titer results (blood test for immunity)
☐ Medical or religious waiver (medical waiver must be signed by health provider)

ATTACH COPY OF IMMUNIZATION RECORD

Meningitis Response Form

New York State Law requires post-secondary institutions to distribute information about meningococcal disease and vaccination to the students (attached). Please read the form and check one:

☐ I have had meningococcal meningitis immunization within the past 10 years. Date received: ____________
☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I will obtain immunization against meningococcal meningitis within 30 days from my private health care provider or local immunization department. Please submit proof of vaccination.
☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against meningococcal meningitis disease.

Tetanus Response Form

Word of Life recommends that all students are immunized against tetanus, diphtheria, and pertussis (whooping cough). A booster is recommended every 10 years. Please check yes or no.

☐ Yes ☐ No Have you had tetanus immunization within the past 10 years? If so, when? ________________

Tuberculosis Questionnaire

Word of Life recommends that all students are screened for tuberculosis. Please answer the following questions to the best of your ability. We will contact you if further action or information is required.

☐ Yes ☐ No Have you ever had a positive TB test or been treated for TB?
☐ Yes ☐ No Have you ever had close contact with anyone who was sick with TB?
☐ Yes ☐ No Do you have HIV, another condition that weakens the immune system, or use illegal drugs?
☐ Yes ☐ No Do you have any of the following symptoms: fever, night sweats, cough, or weight loss?
☐ Yes ☐ No Are you from Latin America, the Caribbean, Africa, Asia, Eastern Europe, or Russia? If yes, which country and when did you live there?
☐ Yes ☐ No Do you live or work in a homeless shelter, prison, jail, or nursing home?

Response and Consent

I have reviewed the submitted health and immunization history and attest that it is true to my knowledge. I understand that the information is strictly confidential and will not be released without my consent, unless otherwise permitted by law. I hereby authorize medical treatment recommended by Word of Life Health Center.

Student Signature ___________________________ Date ____________

Parent Signature (if under 18) ___________________________ Date ____________

Send to Word of Life Health Center by Mail: PO BOX 129 Pottsville, NY 12860, Fax: 518-494-1487, or E-mail: healthcenter@wol.org
NY Health Form

Student Information

Name: _______________________________ Date of Birth: ___/___/____ SSN: _______________________________

Address: ____________________________________________________________

Gender: ☐ Male ☐ Female Cell: (____) ______________ E-mail: _______________________________

Emergency Contact

☐ Parent/Guardian ☐ Spouse Name: _______________________________

Home: (____) ______________ Cell: (____) ______________ E-mail: _______________________________

Health History

ALLERGIES ☐ Food ☐ Medication ☐ Environmental ☐ None

Please list all allergies and reactions: ____________________________________________________________

MEDICATIONS – are you currently taking any medications? ☐ Yes ☐ No

Please list all medications and reason for each: ____________________________________________________

MEDICAL / SURGICAL HISTORY

☐ Yes ☐ No Asthma / wheezing ☑ Yes ☐ No Recurrent / chronic illnesses

☐ Yes ☐ No Diabetes ☐ Yes ☐ No Recent infectious disease

☐ Yes ☐ No Seizure disorder ☐ Yes ☐ No Frequent headaches

☐ Yes ☐ No Heart / Lung problems ☐ Yes ☐ No Glasses / contacts / protective eyewear

☐ Yes ☐ No Back / joint problems ☐ Yes ☐ No ADD / ADHD

☐ Yes ☐ No Fainting or dizziness ☐ Yes ☐ No Mental / Emotional Treatment

☐ Yes ☐ No Recent injury ☐ Yes ☐ No Activity Restrictions

☐ Yes ☐ No Surgery or hospitalization ☐ Yes ☐ No Other (explain below)

Please explain any yes answers: ________________________________________________________________

Health Care Providers

Name of Primary Care Provider: _______________________________ Phone: _______________________________

Name of Specialist (if applicable): _______________________________ Phone: _______________________________

Insurance Information

Do you have Health Insurance? ☐ Yes ☐ No

Name of Plan: _______________________________ Subscriber’s Name: _______________________________

Subscriber’s DOB: _______________________________ Subscriber’s SSN: _______________________________

ATTACH COPY OF INSURANCE CARD