CAL MARITIME

# Student Health Center

The California State University Maritime Academy has health requirements for all degree programs because every student participates in an international experience which may include at least one training cruise. In addition, degree programs for which maritime licensing are a graduation requirement have additional physical and mental health requirements as determined by the U.S. Coast Guard.

**In this section you will find the required health forms to be completed by you and your licensed healthcare provider (must be a U.S. licensed medical professional MD, DO, PA, or NP) and returned to the Student Health Center by May 1, 2017:**

- Health Report (7 pages total)
  - Student to complete pages 1, 2, 5, 6, & 7
  - Provider to complete pages 3 & 4; review and sign pages 2, 3 & 4
- Information About Meningococcal Disease and Immunization
- Notice of Privacy Practices
- Abridgement of Drug Testing Policy

Your Health Report may affect your eligibility for enrollment in certain majors. Therefore, it should be fully completed and returned as soon as possible, but no later than **May 1, 2017 or within two weeks after the date you receive your acceptance letter, whichever is later**. **Those who wish a priority medical review prior to May 1st may receive one if the forms are submitted by April 1st, 2017. Receipt of the Health Report by April 1st, 2017 will ensure a full refund of your deposit in the event you are found ineligible for enrollment in certain majors due to health reasons.** Additional medical documentation may be requested based on information contained in your Health Report. If requested please send this information to the Student Health Center as soon as possible. **Delays in submitting requested information or incomplete forms will hold up your registration for classes.**

**Please mail all health information to the address below:**

**Cal Maritime**
**Student Health Center**
**200 Maritime Academy Drive**
**Vallejo, CA 94590**

Any questions with regards to the Health Report may be directed to the Student Health Center at (707) 654-1170 or you may visit our web site at http://www.csum.edu/web/health-services/.

**Mandatory Health Insurance Requirement-This form is NOT an Insurance Waiver**
Due to the special nature of the educational experience at the Academy, which includes a training cruise and/or international travel, students are required to be covered by health insurance which includes worldwide coverage and travel assistance services. **You will automatically be enrolled in, and charged for Cal Maritime's Health Insurance and Travel Assistance programs. If you have personal insurance that meets Cal Maritime's minimum requirements, you may be eligible for an annual insurance waiver. You must apply online for a waiver by the August, 2017 deadline.** Please visit the Student Health Center website at http://www.csum.edu/web/health-services/required-health-insurance for the deadline date, more information about these specific requirements and to find the link to apply for the annual waiver.

***It is the student's responsibility to inform Cal Maritime when his/her health coverage changes.***

CAL MARITIME

# Health Report

**Major**: _____

## STUDENT INFORMATION

Name _____
Last First Middle

Address _____
Street City State Zip

Birth date ___ ___/___ ___/___ ___ ___ ___ Age _____ ❑ Female ❑ Male ❑ _____

E-mail _____ Cell Ph # (_____) _____

## EMERGENCY CONTACT INFORMATION

Name _____
Last First Middle

Relationship _____

Work (____) _____ Home (____) _____

E-mail _____ Cell Ph # (_____) _____

## ADMISSION HEALTH REPORT

The Admission Health Report is the foundation of each student's medical record at Cal Maritime and is used for all admitted Cal Maritime students including those seeking U.S. Coast Guard licensure and students in majors not associated with licensure. The U.S. Coast Guard determines eligibility for licensure and admission to Cal Maritime is not a guarantee of subsequent licensure. Health information submitted is accessible by the staff of the Student Health Center and Athletic Trainer. *Medical treatment information* is not released without written authorization of the student, a subpoena, and/or as specified by law including the Federal Education Records and Privacy Act.

My signature below attests that all information I have reported is true and complete to the best of my knowledge. I have not knowingly omitted any information relevant to these forms. I further attest that I will inform the Cal Maritime Student Health Center of any change in health status once enrolled, including but not limited to new diagnoses, change of medication, surgery, or hospitalization. Failure to provide current, accurate information may jeopardize enrollment at Cal Maritime or the ability to qualify for U.S. Coast Guard licensure.

**Student's signature:**_____**Date:**_____

## CONSENT FOR TREATMENT

I hereby give consent to the clinical staff of the Student Health Center at California State University, Maritime Academy for medical examinations, preventive care, medical or surgical treatment of illness and/or injuries, diagnostic procedures (including x-ray and laboratory tests), administration of drugs, or for any other care when any or all of the foregoing is deemed necessary by, and is to be rendered under the general supervision of a qualified California licensed health care provider.

I further grant permission for the Cal Maritime Athletic Trainer to access my health information related to participation in team sports or if needed for the treatment of a sports related medical condition.

My confidential medical record will not be released for non-treatment related purposes without my written permission, except by subpoena or other legally required reporting. I also understand that the Student Health Center is limited in its ability to provide continuous and/or comprehensive health care as the Student Health Center is closed in the evenings, on weekends, and during holidays, and the provision of care is based on enrollment status.

I understand that I am free to withdraw my consent for treatment at any time, and that this consent will remain in effect until I give notice that I choose to terminate it.

**Student's signature:**_____**Date:**_____
**Parent's signature** (if student is under 18 y.o.)**:**_____**Date:**_____

CAL MARITIME PHYSICAL EVALUATION

**STUDENT HISTORY FORM** **Date of Exam** _____

***(Note: This form is to be filled out by the student (and/or parents if student is under age 18) prior to seeing the provider.***

Name _____Date of Birth _____

Sex _____ Age _____Year _____ Sport(s) (If applicable) _____

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

Do you have any allergies? ❑ Yes ❑ No If yes, please identify specific allergy: ❑ Medicines ❑ Pollens ❑ Food ❑ Stinging insects

**Explain "Yes" answers below, Circle questions you don't know the answers to.**

| GENERAL QUESTIONS | Yes | No | MEDICAL QUESTIONS | Yes | No |
|---|---|---|---|---|---|
| 1. Has a doctor ever denied or restricted participation in sports for any reason? | | | 26. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 2. Do you have any ongoing medical conditions? If so, please identify below: ❑ Asthma ❑ Anemia ❑ Diabetes ❑ Infections Other: _____ | | | 27. Have you ever used an inhaler or taken asthma medicine? | | |
| 3. Have you ever spent the night in the hospital? | | | 28. Is there anyone in your family who has asthma? | | |
| 4. Have you ever had surgery? | | | 29. Were you born without or are missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| **HEART HEALTH QUESTIONS ABOUT YOU** | **Yes** | **No** | 30. Do you have groin pain or a painful bulge or hernia in the groin area? | | |
| 5. Have you ever passed out or nearly passed out DURING or AFTER exercise? | | | 31. Have you had infectious mononucleosis (mono) within the last month? | | |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | | 32. Do you have any rashes, pressure sores, or other skin problems? | | |
| 7. Does your heart ever race of skip beats (irregular beats) during exercise? | | | 33. Have you had herpes or MRSA skin infection? | | |
| 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ❑ High blood pressure ❑ A heart murmur ❑ High cholesterol ❑ A heart infection ❑ Kawasaki disease Other: _____ | | | 34. Have you ever had a head injury or concussion? | | |
| | | | 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram? | | | 36. Do you have a seizure disorder? | | |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise? | | | 37. Do you have headaches with exercise? | | |
| 11. Have you ever had an unexplained seizure? | | | 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | | |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise? | | | 39. Have you ever been unable to move your arms or legs after being hit or falling? | | |
| **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** | **YES** | **NO** | 40. Have you ever become ill while exercising in the heat? | | |
| 13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? | | | 41. Do you get frequent muscle cramps when exercising? | | |
| 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia? | | | 42. Do you or someone in your family have sickle cell trait or disease? | | |
| | | | 43. Have you had any problems with your eyes or vision? | | |
| 15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? | | | 44. Have you had any eye injuries? | | |
| 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? | | | 45. Do you wear glasses or contact lenses? | | |
| **BONE AND JOINT QUESTIONS** | **YES** | **NO** | 46. Do you wear protective eyewear, such as goggles or a face shield? | | |
| 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? | | | 47. Do you worry about your weight? | | |
| 18. Have you ever had any broken or fractured bones or dislocated joints? | | | 48. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? | | | 49. Are you on a special diet or do you avoid certain types of foods? | | |
| 20. Have you ever had a stress fracture? | | | 50. Have you ever had an eating disorder? | | |
| 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) | | | 51. Do you have any concerns that you would like to discuss with a doctor? | | |
| 22. Do you regularly use a brace, orthotics, or other assistive device? | | | **FEMALES ONLY** | | |
| 23. Do you have a bone, muscle, or joint injury that bothers you? | | | 52. Have you ever had a menstrual period? | | |
| 24. Do any of your joints become painful, swollen, feel warm, or look red? | | | 53. How old were you when you had your first menstrual period? | | |
| 25. Do you have any history of juvenile arthritis or connective tissue disease? | | | 54. How many periods have you had in the last 12 months? | | |

**Explain "yes" answers here:** _____

_____

_____

_____

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of Student_____ Signature of parent/guardian_____ Date_____

(if student is under age 18)

***Must be Reviewed by Provider*-Provider Name: _____Provider Signature:_____ Date:_____**

**HEALTH HISTORY - TO BE FULLY COMPLETED BY MEDICAL PROVIDER, ANY INCOMPLETE SECTION/PAGE WILL BE RETURNED FOR COMPLETION. MUST SUBMIT ALL ORIGINAL FORMS.**

**Student's Name**:_____ **DOB**:_____ **Student ID#**:_____

***(Note: Accurate reporting of medical & psychological conditions ensures continuity of care. Students are encouraged to remain on any prescribed psychiatric medications and report the name and dosage of the medication on this form. Students with medical or mental health condition(s) applying to a licensed track program may be advised that they have a medical condition subject to further review by the US Coast Guard.)***

| **List all Current Medications:** | **List all Allergies:** |
|---|---|
| ☐ **NONE** | ☐ **NKDA** |

**Check YES if the patient has or previously had any of the following diseases/conditions, or NO if not.**

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ❑ | ❑ | Eye Disease/Visual Impairment | ❑ | ❑ | Asthma or Lung Disease |
| ❑ | ❑ | Speech Impediment | ❑ | ❑ | Thyroid Dysfunction |
| ❑ | ❑ | Hearing Loss Disorders | ❑ | ❑ | Diabetes |
| ❑ | ❑ | Loss of Memory | ❑ | ❑ | Tuberculosis or TB Contact |
| ❑ | ❑ | Periods of Unconsciousness | ❑ | ❑ | Chicken Pox |
| ❑ | ❑ | Sleep Walking | ❑ | ❑ | Measles |
| ❑ | ❑ | Impaired Balance or Coordination | ❑ | ❑ | Mumps |
| ❑ | ❑ | Blood Disease | ❑ | ❑ | Other Infectious Disease:_____ |
| ❑ | ❑ | Malignancy | ❑ | ❑ | Learning Disorder |
| ❑ | ❑ | Heart or Vascular Disease | ❑ | ❑ | Autism Spectrum Disorder (ASD) |
| ❑ | ❑ | High Blood Pressure | ❑ | ❑ | Depression |
| ❑ | ❑ | Heart Surgery | ❑ | ❑ | Suicide Attempt |
| ❑ | ❑ | Orthopedic Problems | ❑ | ❑ | Attention Deficit/Hyperactivity Disorder (ADHD) |
| ❑ | ❑ | Impaired Range of Motion | ❑ | ❑ | Bipolar Disorder |
| ❑ | ❑ | Gastrointestinal Disorders | ❑ | ❑ | Substance Use Disorder |
| ❑ | ❑ | Renal Disease | ❑ | ❑ | Generalized Anxiety or Panic Disorder |
| ❑ | ❑ | Chronic Headaches | ❑ | ❑ | Post-traumatic Stress Disorder |
| ❑ | ❑ | Recent or Repetitive Surgery | ❑ | ❑ | Other Psychiatric/Psychological Diagnosis or |
| ❑ | ❑ | Neurological Disorder | | | Disorder:_____ |

****Please Explain Any/All YES Answers****

_____

_____

_____

_____

**PLEASE PROVIDE COMPLETE IMMUNIZATION RECORDS AND/OR PROOF OF IMMUNITY FOR THE LISTED VACCINES BELOW AND TB TESTING RESULTS.**

**Tuberculin Skin Test** Date Given:_____
**(Within 1 year)** Date Read:_____ **Results**:_____**Induration**:_____**mm**
**Or negative CXR within 5 years if history of positive PPD.**

**MMR** Date: **#1**_____
Date: **#2**_____ **Tetanus/TDAP (Within 10 years)** Date:_____

**Varicella (Chicken Pox)** Date: **#1**_____ **Polio** Date: **#1**_____ **#3**_____
Date: **#2**_____ Date: **#2**_____ **#4**_____

**Hepatitis B** Date: **#1**_____ **Hepatitis A** Date: **#1**_____ **Meningococcal** Date:_____
Date: **#2**_____ Date: **#2**_____ **(Within 5 years)** Type:_____
Date: **#3**_____

**Provider Name:**_____**Provider Signature:**_____**Date:**_____

**PHYSICAL EXAM - TO BE FULLY COMPLETED BY MEDICAL PROVIDER, ANY INCOMPLETE SECTION/PAGE WILL BE RETURNED FOR COMPLETION. MUST SUBMIT ALL ORIGINAL FORMS.**

**Student's Name**:_____ **DOB**:_____**Student ID#**:_____

**Blood Pressure:**_____ **Pulse**:_____ **Height**:_____ **Weight**:_____ **BMI**:_____

## Vision

### Field of Vision

*Applicant must have at least 100* horizontal field of vision.*

Normal: _____ Abnormal:_____

### Visual Acuity

*If Corrected vision is measured, uncorrected vision must also be measured.*

**Uncorrected Vision**
Right Eye:____/____
Left Eye:____/_____

**Corrected Vision**
Right Eye:____/_____
Left Eye:____/_____

### Color Vision

*Only one of the following USCG approved tests is required. Please check which test was used and outcome.*

- ☐ ***Pseudoisochromatic Plates***-(Dvorine, 2nd Edition; AOC (1965); revised edition AOC-HRR
- ☐ ***Ishihara 14-24-or 38 plate editions***
- ☐ ***Eldridge-Green Color Perception Lantern***
- ☐ ***Keystone Orthoscope***
- ☐ ***Keystone Telebinocular***
- ☐ ***SAMCTT*** (School of Aviation Medicine Color Threshold Tester)
- ☐ ***Titmus Optical Vision Tester***
- ☐ ***Williams Lantern***
- ☐ ***Hardy, Rand and Rittler (HRR) Pseudoisochromatic Plates*** (PIP) 4th Edition-24 plates
- ☐ ***Farnsworth Lantern (FALANT)***
- ☐ ***FAA OCVT color vision test***-Test per instruction booklet.
- ☐ ***Richmond (1983)***
- ☐ ***Optec 900***
- ☐ ***OPTEC 5500***-Test per instruction booklet.
- ☐ ***Wagoner Plate Test***-14 plates; 24 plates
- ☐ ***Optec 2000***
- ☐ ***Farnsworth D15*** ***ACCEPTABLE FOR ENGINEERS ONLY***-15 plates

**Color Vision Test Results: Pass**_____ **Fail**_____

If Failed, please explain extent of color deficiency:_____

_____

_____

_____

**After considering the history and physical examination, in your professional opinion is this patient able to meet the physical and emotional demands of seagoing life/international travel/sports:**

- ☐ Fully Cleared Without Restriction(s)
- ☐ Cleared With Restriction(s)-(Please List Restriction(s))
  _____.
- ☐ Not Cleared

## Hearing

### Hearing *(Whisper test at 12 ft)*

*If hearing is abnormal, audiogram must be submitted*

Normal:_____ Abnormal:_____

## Physical

**Check each item in proper column enter N.E. if not evaluated**

| Medical | Normal | Abnormal | Give details of each abnormality |
|---|---|---|---|
| Appearance-No indication of Marfan Syndrome | | | |
| HEENT | | | |
| Lymph nodes | | | |
| Heart | | | |
| Pulses-Simultaneous femoral and radial pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Skin | | | |
| Neurologic | | | |
| Genitourinary (males only) | | | |
| **Musculoskeletal** | | | |
| Neck | | | |
| Back | | | |
| Shoulders/Arms | | | |
| Elbows/Forearms | | | |
| Wrists/Hands/Fingers | | | |
| Hips/Thighs | | | |
| Knees | | | |
| Legs/Ankles | | | |
| Feet/Toes | | | |
| Functional-Duck walk, single leg hop | | | |

### Basic Physical Strength & Ability (Please check yes or no)

Based on the history and physical do you estimate that the patient has the agility, strength and flexibility to be able to do the following:

- **-Participate in all physical activity?** **Yes**___ **No**___
- **-Wear a respirator?** **Yes**___ **No**___
- **-Climb Steep or Vertical Ladders?** **Yes**___ **No**___
- **-Maintain Balance on a moving deck?** **Yes**___ **No**___
- **-Pull heavy fire hoses up to 400' & have the ability to lift fully charged fire hoses?** **Yes**___ **No**___
- **-Step over door sills of 24" in height?** **Yes**___ **No**___
- **-Rapidly don an exposure suit?** **Yes**___ **No**___
- **-Open or close water tight doors that may weigh up to 56 pounds?** **Yes**___ **No**___

**Additional Comments:**_____

_____

**Name of Examining Provider:**_____**License#:**_____

**Provider's Signature:**_____**Date:**_____**Telephone#:**_____

**Clinic Address:**_____**City:**_____**State:**_____**Zip Code:**_____

CAL MARITIME

**Student ID #: _____**

## Abridgment of Drug Testing Policy

It is the policy of Cal Maritime to be in compliance with the Federal Drug-Free Schools and Communities Act Amendments of 1989, as well as the U. S. Coast Guard regulation regarding mandatory drug testing per 46 CFR, Parts 4, 5, and 16 and 49 CFR, Part 40.

The purpose of this policy is to:

1. Promote education.
2. Minimize the use of intoxicants by merchant marine personnel.
3. Promote a drug-free and safe work environment.
4. Set forth minimum standards, procedures, and means to be used to test for the use of dangerous drugs.

The Federal Drug-Free Schools and Communities Act Amendments of 1989 (20 U.S.C.; 1145g) and Cal Maritime prohibit the unlawful possession, use, sale, or distribution of alcohol and illegal drugs by students, faculty, and staff on its property, training vessels, or as part of any Academy-sponsored activities. This prohibition extends to any off-campus activities that are sponsored by Cal Maritime or any of its recognized clubs and organizations. Under the auspices of the U.S. Department of Transportation (DOT), the U.S. Coast Guard has issued regulations establishing mandatory drug testing and drug abuse education programs (46 CFR, Parts 4, 5, and 16). These regulations are applicable to the marine transportation industry and all operators of marine vessels, crewmembers, pilots, licensed officers, holders of merchant mariner's documents, or watch standers (who are not regular crewmembers) of non-recreational vessels, including all Cal Maritime cadets (students).

Cal Maritime as directed by 49 CFR Part 40 and amendments thereto, will **randomly drug test all cadets.** Drug testing begins the first month of fall semester and continues through the end of cruise. The following drugs are routinely tested by analyzing a urine specimen: **Marijuana, Cocaine, Opiates, Amphetamines, and Phencyclidine (PCP).** In addition, CMA reserves the option of testing for other dangerous drugs, alcohol, and the presence of adulterants.

"Random drug testing" means that every cadet has a substantially equal chance of selection for drug testing on a statistically valid basis through their enrollment at Cal Maritime. The random selection process is accomplished by a non-university third-party administrator. Approximately one-half (50 percent) of the cadets enrolled during a given academic year will be tested on the basis of random selection.

Drug Testing may also be conducted for the following reasons:

1. Pre-employment or baseline test.
   A marine employer must conduct a drug test prior to employing or giving a commitment of employment to any crewmember. The prospective employee must actually pass the test before being employed.
2. Periodic Testing.
   Whenever a person is required to have a physical examination under the U.S. Coast Guard regulations, a drug test may be required.
3. Reasonable Cause (Drug and Alcohol).
   Cal Maritime is required to drug test any cadet involved in vessel operations who is reasonably suspected of using a dangerous drug or being under the influence of drugs or alcohol. The following examples are grounds for "reasonable cause."
   a. Direct observation of drug use or physical evidence of such use.
   b. Physical, behavioral, or performance indicators of use or intoxication. This may include slurred and incoherent speech, lack of coordination and balance, nodding or dozing off on watch, frequent absences from assigned duties or class, mood or attitudinal changes, general appearances, evidence of drug paraphernalia, and smoke or body odors.
   c. Suspicion of an adulterated or substituted urine specimen rejected by the lab for testing.
4. Follow-Up Testing.
   The Substance Abuse Professional may direct a cadet to take a drug test when a previous test was failed or refused and prior to reinstatement of safety sensitive duties.
5. Marine Casualty, Accident, or Serious Incident.
   U.S. Coast Guard requires testing for drugs and alcohol of any individual directly involved in a serious marine incident, marine casualty or accident.

Any cadet failing a drug/alcohol test in accordance with this policy may be presumed to be a user of dangerous drugs/alcohol. Thereafter, the following actions may be carried out immediately by the Student Conduct Administrator:

1. The cadet may be removed from all duties which affect the safe operation and security of the Training Ship and campus, including but not limited to, watch standing, operation of equipment or handling of dangerous chemicals, and assumption of command responsibilities.
2. The cadet shall be offered campus support services, including education and training, counseling, and referral to off-campus agencies appropriate to the nature of the drug abuse problem.
3. The cadet will be referred to a DOT certified Substance Abuse Professional for further evaluation and follow up.
4. Cadets will be referred to the Discipline Review and Investigation Committee for disciplinary action as specified by the REGULATIONS GOVERNING THE CORPS OF CADETS.

I certify that I have read and understand the above summary of the Drug Testing Policy at Cal Maritime and recognize that I will be a participant in the Drug Testing Program while enrolled at the Academy.

| _____ | _____ | _____ |
|---|---|---|
| Name of Applicant (printed) | Signature of Applicant | Date |

CAL MARITIME

**Student ID#: _____**

# AB 1452 Information about Meningococcal Disease and Immunization

**What is meningitis?**
Meningitis is an infection of the fluid of a person's spinal cord and the fluid that surrounds the brain. Meningitis is usually caused by a viral or bacterial infection. Knowing whether meningitis is caused by a virus or bacterium is important because the severity of illness and the treatment differ. Viral meningitis is generally less severe and resolves without specific treatment, while bacterial meningitis can be quite severe and may result in brain damage, hearing loss, learning disability or death. For bacterial meningitis, it is also important to know which type of bacteria is causing the meningitis because antibiotics can prevent some types from spreading and infecting other people. Today, Streptococcus pneumoniae and Neisseria meningitis are the leading causes of bacterial meningitis.

**What of the signs and symptoms of meningitis?**
High fever, headache, and stiff neck are common symptoms of meningitis. These symptoms can develop over several hours, or they may take 1 to 2 days. Other symptoms may include nausea, vomiting, discomfort looking into bright lights, rash, flu like symptoms, confusion, and sleepiness. As the disease progresses, patients of any age may have seizures.

**How is meningitis diagnosed?**
Early diagnosis and treatment are very important. If symptoms occur, the patient should see a doctor immediately. The diagnosis is usually made by growing bacteria from a sample of spinal fluid. The spinal fluid is obtained by performing a spinal tap, in which a needle is inserted into an area in the lower back, where fluid in the spinal canal is readily accessible. Identification of the type of bacteria responsible is important for selection of correct antibiotics.

**Can meningitis be treated?**
Bacterial meningitis can be treated with a number of effective antibiotics. It is important, however, that treatment be started early in the course of the disease. Appropriate antibiotic treatment of most common types of bacterial meningitis should reduce the risk of dying from meningitis to below 15%, although the risk is higher among the elderly.

**Is meningitis contagious?**
Yes, some forms of bacterial meningitis are contagious. The bacteria are spread through the exchange of respiratory and throat secretions (i.e., coughing, kissing, or using someone's glass). Fortunately, none of the bacteria that cause meningitis are as contagious as things like the common cold or the flu, and they are not spread by casual contact or by simply breathing the air where a person with meningitis has been.

However, sometimes the bacteria that cause meningitis have spread to other people who have had close or prolonged contact with a patient with meningitis caused by Neisseria meningitis. People in the same household or anyone with direct contact secretions (such as a boyfriend or girlfriend) would be considered at increased risk of acquiring the infection. People who qualify as close contacts of a person with meningitis caused by Neisseria meningitis should receive antibiotics to prevent them from getting the disease.

**Who Is at Risk for Meningitis?**
Meningitis can strike at any age; however, certain groups have a greater risk for contracting the disease:

- College students, particularly freshmen, who live in campus residence halls.
- Anyone in close contact with a known case.
- Anyone with an upper respiratory infection with a compromised immune system.
- Anyone traveling to areas of the world where meningitis is endemic (prevalent in the region).

**Is There a Vaccine to Help Prevent Meningitis?**

- A safe, effective vaccine is available.
- The vaccine is 85% to 100% effective in preventing four kinds of bacterial infections (serogroups A,C, Y, W-135) that cause about 70% of disease in the U.S.
- The vaccine is safe, with mild side effects, such as redness and pain at the injection site lasting up to 2 days.
- After vaccination, immunity develops within 7 to 10 days and remains effective for a minimum of 3 to 5 years. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals.
- Meningitis B vaccine is now available. Discuss with your medical provider if they recommend receiving this vaccine.

**Is Vaccination Recommended for College Students?**

- Certain college students, particularly freshmen who live or plan to live in residence halls, have a 6-fold increased risk of disease.
- The American College Health Association has adopted the recommendation of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), which states that college students, particularly freshmen, living in residence halls, be vaccinated against meningococcal meningitis.
- Other undergraduate students wishing to reduce their risk of meningitis can also choose to be vaccinated.

*In accordance with Assembly Bill 1452, Chapter 1.7, Section 120395 please acknowledge receipt of this information by completing the box below and returning with your Cal Maritime Health Admission Forms.*

**I have already received this vaccination**

- ❑ **Yes**
- ❑ **No**

**I would like to receive this vaccine**

- ❑ **Yes (if yes, where do you plan on receiving this vaccine? _____)**
- ❑ **No**

_____ _____ _____

**Name of Applicant (Printed)** **Signature of Applicant** **Date**

**If you have any questions, contact Cal Maritime Student Health Center at (707) 654-1170**

CAL MARITIME

# Student Health Center

**Please review our Patient Rights and Responsibilities and Notice of Privacy Practices at:**

**https://www.csum.edu/web/health-services**

**by selecting the link at the bottom of our homepage.**
**Hard copies are also available in the Student Health Center.**
**If you have any questions please feel free to contact the SHC at healthcenter@csum.edu or (707) 654-1170.**

By signing below I acknowledge that I have reviewed the Patient Rights and Responsibilities and Notice of Privacy Practices for the Cal Maritime Student Health Center and I am aware that copies are readily available to me at any time.

_____
**Print full name of patient/student**

_____ _____
**Signature of patient/student** **Date**

If a personal representative's signature appears above please describe relationship to patient/student:_____

_____