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 licensure is 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 3rd, 2021:

- Health Report (8 pages total)
  - Student to complete pages 1, 2, 5, 7, & 8
  - Provider to complete pages 3 & 4; review and sign pages 2, 3, 4 & 5
- CA Tuberculosis Risk Assessment
- Information About Meningococcal Disease and Immunization
- Notice of Privacy Practices

Your Health Report may affect your eligibility for enrollment in and completion of certain majors. Therefore, it should be fully completed and returned as soon as possible, but no later than **May 3rd, 2021 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 3rd may receive one if the forms are submitted by April 1st, 2021. Receipt of the Health Report by April 1st, 2021 will ensure a full refund of the admission deposit if the medical review reveals certain chronic health conditions that (for some majors) prevent receiving professional licenses required for graduation or work in major-related fields.** 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 - Due to the special nature of the educational experience at Cal Maritime, which includes a training cruise and/or international travel, students are required to have health insurance. If you have personal insurance that meets Cal Maritime's minimum requirements, you may be eligible for an annual insurance waiver. This form is **NOT** an insurance waiver. Neither is submitting a copy of an insurance card. **You must apply online to waive Cal Maritime's Health Insurance,** typically between early May to August**.** 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 when it opens.

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

CAL MARITIME

Health Report for Marine Transportation, Mechanical Engineering-USCG License, and Marine Engineering Technology

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 continued eligibility to participate in majors requiring USCG licensure for graduation. Admission to Cal Maritime is not a guarantee of continued enrollment or 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, as specified by state or federal law including the Federal Education Records and Privacy Act, and/or as required by the USCG for licensing purposes.

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. Medical Records are retained for 10 years after the most recent activity or visit date.

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:**_____

A CAMPUS OF THE CALIFORNIA STATE UNIVERSITY

Address	***Phone***	***Fax***
Cal Maritime Student Health Center *200 Maritime Academy Drive* *Vallejo, CA 94590-8181*	*707-654-1170* *www.csum.edu/web/health-services*	*707-654-1171*

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

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 all "YES" answers here and any conditions not included above:_____

_____

_____

_____

_____

_____

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 and Any Conditions Not Included Above****

_____

_____

_____

_____

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

Tuberculin Risk Assessment Required:
Complete Attached Screening Form If Screening is Positive Attach Documentation of Test Performed with Results.

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

COVID-19 Vaccine Date: **#1**_____Date: **#2**_____
Type:_____

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

Hepatitis B Date: **#1**_____ **Hepatitis A** Date: **#1**_____ **Meningococcal** Date(s):_____
Date: **#2**_____ Date: **#2**_____ **(Within 5 years)** Type(s):_____
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	Corrected Vision
Right Eye:____/_____	Right Eye:____/_____
Left Eye:____/_____	Left Eye:____/_____

Color Vision
Applicant must be tested on at least one of the USCG approved color vision tests listed below. Please check which test was used and the result.

- ☐ ***Pseudoisochromatic Plates***-(Dvorine, 2nd Edition; AOC; revised edition or AOC-HRR; **Ishihara 14-, 24-, or 38-plate editions**).
- ☐ ***Titmus Vision Tester/OPTEC 2000***
- ☐ ***Farnsworth Lantern***
- ☐ ***Richmond Test, 2nd and 4th edition***
- ☐ ***Optec 900***

Color Vision Test Results: Pass_____ Fail_____
If Failed, please explain extent of color deficiency:_____
_____
_____
_____

Please advise patient to contact us regarding any color vision abnormalities at (707) 654-1170.

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' & and be able 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:**_____

California Tuberculosis Risk Assessment
College and University Students

- Use this tool to identify asymptomatic **college or university students** for latent TB infection (LTBI) testing.
- **Do not repeat testing** unless there are **new risk factors** since the last negative test.
- Do not treat for LTBI until active TB has been excluded:
  For patients with TB symptoms or abnormal chest x-ray consistent with active TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing.
  A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.

LTBI testing is recommended if any of the 3 boxes below are checked.

☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-U.S.-born persons ≥2 years old

☐ **Immunosuppression**, current or planned

HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease during lifetime

Treat for LTBI if LTBI test result is positive and active TB disease is ruled out.

☐ **None**; no TB testing is indicated at this time

Provider: _____

Assessment Date: _____

Patient Name: _____

Date of Birth: _____

See the **College and University Students Risk Assessment User Guide** for more information about using this tool.
To ensure you have the most current version, go to the RISK ASSESSMENT page at https://www.cdph.ca.gov/tbcb

September 2019

CA College and University Students TB Risk Assessment User Guide

Avoid testing persons at low risk
Routine testing of low risk populations is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

Local recommendations and other risk factors
The core elements listed in the College/University TB Risk Assessment are meant to identify students who need screening for TB. These were selected in order to focus testing on patients at highest risk. This risk assessment does not supersede any mandated testing. Examples of these populations include: healthcare workers, residents or employees of correctional institutions, substance abuse treatment facilities, homeless shelters, and others. Local recommendations should also be considered in testing decisions. Local TB control programs can customize this risk assessment according to local recommendations. **Providers should check with local TB control programs for local recommendations.**

United States Preventive Services Task Force (USPSTF)
The USPSTF has recommended testing foreign born persons born-in or former residents of a country with an elevated tuberculosis rate and persons who live in or have lived in high-risk congregate settings such as homeless shelters and correctional facilities. Because the increased risk of exposure to TB in congregate settings varies substantially by facility and local health jurisdiction, clinicians are encouraged to follow local recommendations when considering testing among persons from these congregate settings. USPSTF did not review data supporting testing among close contacts to infectious TB nor among persons who are immunosuppressed because these persons are recommended to be screened by public health programs or by clinical standard of care.

Most patients with LTBI should be treated
Because testing of persons at low risk of TB infection should not be done, persons that test positive for LTBI should generally be treated once active TB disease has been ruled out with a chest radiograph and, if indicated, sputum smears, cultures, and nucleic acid amplification testing (NAAT) have been performed. However, clinicians should not be compelled to treat low risk persons with a positive test for LTBI.

When to repeat a risk assessment testing
Repeat risk assessments should be based on the activities and risk factors specific to the student. Colleges and universities may decide on the need for repeat screening based on the activities and risk factors specific to their student body. Students who volunteer or work in health care settings might require annual testing and should be considered separately.

Re-testing should only be done in persons who previously tested negative, and have new risk factors since the last assessment. In general, this would include new close contact with an infectious TB case or new immunosuppression, but could also include foreign travel in certain circumstances.

Negative test for latent TB does not rule out active TB
It is important to remember that a negative TST or IGRA result does not rule out active TB. In fact, a negative TST or IGRA in a patient with active TB can be a sign of extensive disease and poor outcome.

Previous or inactive tuberculosis
Persons with a previous chest radiograph showing findings consistent with previous or inactive TB should be tested for LTBI and evaluated for active TB disease.

IGRA preference in BCG vaccinated students
Because IGRA has increased specificity for TB infection in persons vaccinated with BCG, IGRA is preferred over the TST tuberculin skin test in these persons.

Emphasis on short course for treatment of LTBI
Shorter regimens for treating LTBI have been shown to be more likely to be completed and the 12-dose regimen has been shown to be as effective as 9 months of isoniazid. Use of these shorter regimens is preferred in most patients. Drug-drug interactions and contact to drug resistant TB are frequent reasons these regimens cannot be used.

Medication	Frequency	Duration
Rifampin	Daily	4 months
Isoniazid + rifapentine*	Weekly	12 weeks

*The CDC currently recommends DOT for this regimen; however, data has shown that SAT is noninferior to DOT in the United States. Many clinicians are using SAT or modified DOT.

CDPH LTBI Treatment Fact Sheets: Fact sheets are available for three treatment regimens on the California Tuberculosis Branch website, on the LTBI Treatment page at: https://cdph.ca.gov/TB-LTBI-Treatment

What if students refuse LTBI treatment when indicated?
Refusal should be documented. Offers of treatment should be made at future encounters with medical services if still indicated. Annual chest radiographs are not recommended in asymptomatic students. If treatment is later accepted, TB disease should be excluded and CXR repeated if it has been more than 3 months from the initial evaluation.

Symptoms that should trigger evaluation for active TB
Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB: cough for more than 2-3 weeks, fevers, night sweats, weight loss, hemoptysis or excessive fatigue.

No state requirements for LTBI screening in college or university students
These recommendations are considered best practices by the CDPH TCB and are not legally mandated.

Resource: American College Health Association Guidelines on tuberculosis screening available online: http://www.acha.org/documents/resources/guidelines/ACHA_Tuberculosis_Screening_2017.pdf

Abbreviations: DOT=Directly observed therapy; IGRA= Interferon gamma release assay (e.g., QuantiFERON-TB Gold, T-SPOT.TB); BCG=Bacillus Calmette-Guérin; TST= tuberculin skin test; LTBI=latent TB infection

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:_____

_____