

Academic Year
2009/2010

Dear Students and Parents,

It is our pleasure to welcome you to the University of the Pacific and to introduce you to the Cowell Wellness Center. The Cowell Wellness Center provides student-centered primary care and mental health counseling to Pacific students. We promote optimal wellness and assist students to achieve their academic goals through quality health services.

We strive to continually improve the delivery of our services offered at the Cowell Wellness Center. Health Services are delivered through a Nurse Practitioner/Physician/Physician Assistant/Dietician Team Model and coordinate, when necessary, with Pacific's Counseling Services staff and counseling services are delivered by psychologists and a marriage family therapist. Additionally, we have increased our scope of care to include a partnership with St. Joseph's Medical Group. This partnership allows us to follow students through care beyond all scope of services.

We support the academic mission of the University by educating students about physical and emotional wellness in a manner that enhances their overall health and reduces disease. We respect the diversity of our students and are sensitive to their religious or personal beliefs and practices and strive to provide the best quality care for all.

We encourage you to give us your comments and to become involved in promoting healthy attitudes and lifestyles on our campus. We would like you to become familiar with our services and to stop by or call if you have any concerns or questions. We truly care about our students, and want you to know that all the services provided at the Cowell Wellness Center are confidential.

In order to protect the educational goals of our students, the University requires all students, enrolled for 9 or more units, to have major medical health insurance coverage and pay a health fee each semester. To learn more please read the Health Insurance Requirement form in the enclosed packet. You will be receiving a separate mailing from Aetna Student Insurance by June 2009.

Please have your medical provider complete the enclosed History and Physical form and verify that the immunization requirements have been met. Please submit them to the Cowell Wellness Center as soon as possible, but no later than August 15, 2009. We recommend that the student mail the completed forms to the Cowell Wellness Center in the enclosed envelope.

Thank you and we look forward to meeting and assisting you as you become part of our Pacific family.

Elizabeth Griego

Elizabeth Griego, Ph.D.
Vice President
Division of Student Life

Joanna Royce-Davis

Joanna Royce-Davis, Ph.D.
Dean of Students
Division of Student Life

Kathy Hunter

Kathy Hunter, CRNP, FNP
Director of Health Services
Division of Student Life

NOTICE REGARDING PRIVATE INSURANCE BILLING

Dear Students of Pacific:

We would like to remind you that all enrolled students who have paid the current semester's health fee are eligible for services at the CWC. Additionally, in order to protect student's educational goals, Pacific requires all students, enrolled for 9 or more units, to have major medical health insurance coverage.

Billing Policy:

- **Insurance Plans & Co-Payments** - we accept many Preferred Provider Organization (PPO) and Point of Service (POS) health insurance plans. If you would like to know if we contract with your insurance carrier please contact the Cowell Wellness Center for that information. If we are contracted to do so, we will bill your health insurance carrier directly for services that are covered by your plan. Co-pays are not collected due to the collection of the health fee each semester.
- **Health Service Access** - the health fee, which is a part of the University tuition, supports basic operations of the CWC. CWC may provide medical care to all eligible students regardless of selected payment method: private or student health insurance, cash, check, credit card and PacificCash. Please remember that the payment method selected at the time of service can not be changed after the date of service.
- **HMO** – Health Maintenance Organizations (HMOs) require member patients to seek health services from a specific directory of professionals. Pacific does not contract with HMO's at this time. Students who wish to receive the full benefit of their HMO plans should contact their Primary Care Providers (PCPs). Students who wish to utilize CWC may do so without office visit charges, but may pay a reduced rate for treatment services as needed.
- **Laboratory Orders** – ordered lab tests can be billed to private insurance or paid in full by cash, check, credit card or PacificCash. If billed charges are denied, the insured (policy-holder) is responsible for payment to the laboratory directly. Changes to the billing method can not be made at a later date. CWC contracts with Health Care Clinical Laboratory and Quest Diagnostic Laboratory. Students should determine which laboratories are contracted with their insurance carrier in order to avoid claim denials.
- **Referrals** – when off campus treatment services are needed, CWC staff will provide referrals to the appropriate facility or specialist. The policy holder(s) is responsible for all costs incurred outside of CWC. Students should be aware of the terms of their insurance plans and which hospitals and laboratories are contracted with their insurance carriers. For example, those with Kaiser should go to a Kaiser facility for routine or urgent care and to Dameron Hospital for emergency or inpatient care.
- **Proof of Insurance** - Students are required to bring their insurance cards and Pacific student IDs to each visit. Students are responsible for ensuring that their coverage is current and active throughout enrollment at Pacific. Pacific's mandatory health insurance policy requires that a copy of the front and back of the insurance card is submitted to Pacific's Health Insurance Coordinator prior to the waiver deadline and when there has been a change in coverage or the insurance carrier. A hold will be placed on the student's account if proof of insurance is not provided. The hold will be removed upon verification of valid insurance when provided.
- **Responsibility for Payment of Services** – If CWC receives a denial of payment from your insurance carrier or the invoiced amount is applied toward your deductible; the student will be billed directly by CWC at the fee agreed upon at the time of service.

Authorization for Release & Assignment of Benefits

As we see patients from many insurance plans, it is impossible for us to know all the covered benefits, co-insurance and deductibles for each plan. It is the patient's responsibility to know and be financially accountable for co-insurance, deductibles not met and services not approved or covered by your insurance carrier. While it is our intention to assist you, it is still the patient's responsibility to make certain that all services rendered by the Cowell Wellness Center on the patient's behalf are paid in full. To ensure this, holds can be placed on a student's account for claims that are not paid in a timely manner. Student account holds can affect many areas of the student's life at Pacific and are utilized as a last resort. Holds will be removed within 24 to 72 hours of receipt of payment.

Inaccurate insurance information could lead to unnecessary denials or delays in the payment of benefits. Please make every effort to let us know if your insurance carrier (primary or secondary) or your personal information (home address, employer and phone number) has changed since your last visit.

Cowell Wellness Center staff understands that insurance coverage is very confusing to many people, and we are committed to helping you with any questions you may have. Please feel free to contact us at: 209-946-2315 and press option 1 to speak to a front desk representative who will guide you to the appropriate person.

Statements of Consent

I (the subscriber) request that payment of authorized third party benefits made on my behalf and/or on behalf of all members covered on my insurance plan (who are eligible to receive services at the Cowell Wellness Center) to be paid directly to the Cowell Wellness Center, University of the Pacific for services furnished.

I (the patient) authorize the release of medical information about me needed to determine benefits or benefits payable to related services. I permit a copy of this authorization to be used in place of the original.

SIGNED CONSENT TO BILL PRIVATE INSURANCE: I (we) have read and understand the policy stated above.

Signature of Subscriber/Responsible Party

Please Print Name

Date

Signature of Pacific Student (if different than above)

Please Print Name

Date

Subscriber Contact Number with Area Code

Student ID Number

Patient Lab Service Policy

If your health care provider recommends lab testing as part of your evaluation, you will need to be aware of the information below.

- In house testing must be paid by cash, check, or credit card if not covered by private insurance.
- The Wellness Center is not authorized to bill HMOs.
- For all labs sent out, Cowell Wellness Center has a client bill service negotiated with two local labs. These labs charge a reduced rate for tests when the student pays by cash, check, or credit card. Cowell Wellness Center may charge above the negotiated reduced rate to cover our costs of accession and handling. It is the patient's responsibility to know which lab contracts with the patient's insurance. Cowell Wellness Center utilizes HealthCare Clinical Laboratories and Quest Diagnostics.

Upon your request, Cowell Wellness staff is able to inform you of the discounted cost of any test ordered by our providers. At the time of service, **you must decide** if you would like to take advantage of the **client bill service or bill your private health insurance**. If you choose to bill your private insurance a copy of the insurance card must be attached to the lab slip. **If you do not have your insurance card at the time of service, staff cannot request insurance billing, and you will need to use another form of payment.** If you have any privacy concerns, please speak with your provider prior to selecting your method of billing. Once the method of payment is selected, and the lab has processed the specimen(s), the Wellness Center staff **cannot change** the billing method, the lab order, or amend lab charges.

BILLING PRIVATE HEALTH INSURANCE (non-HMO):

Generally, health insurance policies cover most diagnostic tests; however, certain screening tests may not be covered; HMO insurance and some other types of policies will cover tests only if ordered by a provider in their plan.

If you want to use your insurance, the lab will bill your health insurance directly (usually at a higher rate than client billing). If the bill is denied by the insurance company **for any reason**, you will be responsible for payment in total to the lab that the specimen was sent to. Often the lab will send the insurance subscriber an invoice for the denied amount.

You should be aware of your policy's coverage limits and deductibles. If you have an issue about the amount charged or insurance coverage, you should contact the lab's billing department or your insurance company as appropriate.

OUTSIDE LAB ORDERS:

The Wellness Center will honor lab requisitions from an off campus provider as long as you bring in the lab slip or other written order signed by the provider. The order must contain the test names and associated diagnosis code. The aforementioned policy will apply to any lab work ordered. The lab results will be sent directly to the ordering provider. Wellness Center staff may not receive a copy of test results; you will need to contact the ordering provider for results and follow-up care.

SIGNED CONSENT: My signature below signifies that I have read, understood, and agreed to the above policy.

_____ Signature	_____ Please Print Name
_____ Date of Signature	_____ Student ID Number

Health Requirements (Mandatory):

1. **COMPLETE HEALTH HISTORY AND PHYSICAL EXAMINATION (within 3 months of classes starting):** The attached history and physical form should be completed by the student's personal health care provider. This information is strictly confidential and will be maintained in a secure medical record in the Wellness Center.
2. **TUBERCULOSIS (TB) CLEARANCE (within 3 months of classes starting):** A mantoux skin test must be administered and read by a licensed health care professional. The reading should be stated in **millimeters of induration**, not merely as "positive" or "negative". If the result is positive, the student should receive a chest X-ray with appropriate follow-up. If there is a documented history of a positive TB skin test, a chest X-ray should be performed within three months prior to the start of classes. In accordance with CDC Guidelines, history of BCG vaccination is no longer a reason to avoid mantoux skin testing, and is recommended in order to rule out possible latent TB infection.
3. **IMMUNIZATIONS:**
 - a. **MEASLES, MUMPS, RUBELLA – MMR:** Documentation of 2 doses of MMR.
 - b. **TETANUS/DIPHTHERIA (Td):** Documentation of a booster dose within ten years.
 - c. **DIPHTHERIA/TETANUS & PERTUSSIS (DTaP)** AMA recommended if Td is not current.
 - d. **HEPATITIS B:** 3 doses of Hepatitis B (at 0, 1, and 6 months apart). (*Health Science major see immunization form*). If all 3 doses were given and the Hepatitis surface antibody test is negative, the student will need to repeat the series, on the same schedule as previously. If the student has not completed the series, and will be unable to do so prior to the start of classes, he/she may finish the series with antibody testing through the Wellness Center. If the student has already been exposed to Hepatitis B, vaccination is not indicated and immunity can be documented with a positive core antibody and negative surface antigen. Students with a positive Hepatitis B surface antigen should receive appropriate evaluation and health counseling.
4. **MENINGOCOCCAL VACCINE RECOMMENDED** for incoming freshmen residing on campus.
5. **VARICELLA (CHICKEN POX) VACCINE RECOMMENDED** if no previous history of the disease and is required for all health science majors if no previous history of the disease.
6. **HEALTH INSURANCE:** All students are required to carry major medical insurance. There are two options to meet this requirement: 1) The University Student Health Insurance Plan (Aetna via The Chickering Group), billed to the student account, or 2) Waiver of the University Student Health Plan with proof of current major medical coverage that meets minimum requirements.

HISTORY AND PHYSICAL (General or Entrance)

This document consists of a History and Physical (pages 1 and 2), and an Immunization/TB Clearance (page 3). It is to be completed by a Physician, Nurse Practitioner or Physician's Assistant, signed and dated on page 2 and 3.

STUDENT'S NAME: _____ **DATE:** _____

DATE OF BIRTH: _____ **SEX:** _____ **ID #:** _____

LOCAL ADDRESS: _____

PHONE NUMBER: _____ **MAJOR:** _____ **GRAD DATE:** _____

PAST MEDICAL HISTORY:

1. Significant past health problems, major illnesses/injuries, surgeries, hospitalizations:

2. Childhood Diseases: _____
3. Medications (Prescribed, Vitamins, Supplements, OTC) within the last 3 months:

4. Drug allergies & reactions: _____

FAMILY HISTORY:

1. Parents: _____
2. Siblings: _____

SOCIAL HISTORY:

1. Employment: _____
2. Exercise program: _____
4. Dietary Patterns: _____

SUBSTANCE USE:

Alcohol: _____ Tobacco: _____ Recreational Drugs: _____

REVIEW OF SYSTEMS:

General: _____ **Ears:** _____

Skin: _____ **Nose:** _____

Head: _____ **Throat:** _____

Eyes: _____ **Mouth:** _____

NAME: _____ ID #: _____

ROS: _____
Breasts: _____ Ob/Gyn: _____

Resp: _____ MS: _____

CV: _____ Neuro/Psych: _____

GI: _____ Heme/Lymph: _____

GU: _____ Endo: _____

Other: _____

PHYSICAL EXAMINATION:

Ht _____ Wt _____ BMI _____ BP _____ Pulse _____ Resp _____ Temp _____

Visual Acuity Right 20/ _____ Left 20/ _____ Both 20/ _____ uncorrected corrected

Sexually Active: Yes _____ No _____ Number of Children: _____

(Write "N/A" if item does not apply to student)

GENERAL/Mental Status: _____

SKIN: _____ LUNGS: _____

HEAD: _____ CV: _____

EYES: _____ ABD: _____

EARS: _____ EXT: _____

NOSE: _____ NEURO: _____

THROAT: _____ GU MALE: _____

NECK: _____ LAST PELVIC RESULT: _____ DATE: _____

BREASTS: _____ HPV VACCINE: #1 _____ #2 _____ #3 _____

ASSESSMENT AND PLAN:

1. Health recommendations: _____
2. Please review the student's immunization status, provide the necessary vaccines and/or titers to complete entrance requirements, and record all information on page 3.
3. Please review the student's TB status, provide appropriate documentation of TB clearance to complete entrance requirements, and record all information on page 3.

Signature of Provider/Printed Name Date

Address of Provider Phone/Fax Numbers

IMMUNIZATION HISTORY

Vaccine Type	Date Given	PCP Initials	Result	Report Attached	Health Science Requirement	Major
Hepatitis B #1			N/A	N/A	yes	
Hepatitis B #2			N/A	N/A	yes	
Hepatitis B #3			N/A	N/A	yes	
Hepatitis Surface Antibody				yes	yes	
Hepatitis B #4			N/A	N/A	yes, if non-immune restart series	
Hepatitis B #5			N/A	N/A	yes, if non-immune	
Hepatitis B #6			N/A	N/A	yes, if non-immune	
2nd Hepatitis Surface Antibody				yes	yes, if series repeated	
Meningitis			N/A	N/A	no	
MMR #1			N/A	N/A	yes	
MMR #2			N/A	N/A	yes	
and/or MMR Titer				yes	yes, if no proof of #1 & #2	
Td			N/A	N/A	yes, within last 10 years	
DTaP			N/A	N/A	no, if Td is current	
Varivax #1				N/A	yes, if no prev hx of disease	
Varivax #2				N/A	yes, if no prev hx of disease	
and/or Varicella Titer				yes	yes, if prev hx of disease	
Other Vaccination (optional)					no	
Other Vaccination (optional)					no	
Other Vaccination (optional)					no	
BCG Vaccine (Intl. Students)			N/A	N/A	no	
Chest X-Ray				yes	yes, if prev pos ppd hx	
Updated Chest X-Ray				N/A	Cowell Wellness Use Only	
PPD Date Placed	PPD Date Read	Initials	Induration	Attach Report	Health Science Req.	
1st Placement Date:				N/A	yes, within 3 months of Aug.	
2nd Placement Date:				N/A	yes, 7-14days after 1st placement	
Placement:				N/A	Cowell Wellness Use Only	
Placement:				N/A	Cowell Wellness Use Only	
Placement:				N/A	Cowell Wellness Use Only	

STUDENT NAME: _____

STUDENT ID: _____

Provider Office Stamp:

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes.

You may request a copy of our Notice any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. As an educational institution, your health information may be accessed by students, residents, faculty and staff.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying, or locating) a family member, your personal representative or another person responsible for your care. This health information may include your location, your general condition, or your death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences in your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we have a reason to believe that you are a possible victim or abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others.

National Security: We may disclose your health information to military authorities, or Armed Forces personnel under certain circumstances. We may also disclose to authorized federal officials health information required for lawful intelligence,

counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or a patient, under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we reserve the right to charge \$0.10 for each page, \$1.00 for each sheet of x-rays duplicated, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have any questions or concerns, please contact us.

If you believe your privacy rights have been violated, you may file a complaint with the below mentioned Privacy Officers, or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Contact Information

Privacy Officer: Deborah Beitz, University of the Pacific, 3601 Pacific Stockton, CA 95211 (209) 946-2124 dbeitz@uop.edu

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

☞ You May Refuse To Sign This Acknowledgement ☞

I have received a copy of this office's Notice of Privacy Practices.

(Please Print Name)

(Signature)

(Student ID Number)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign.
- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (Please Specify): _____

ACKNOWLEDGEMENT OF
NO SHOW-CANCELLATION POLICY
AND FEE SCHEDULE

The health and counseling services staff at the Cowell Wellness Center provides quality care to an average of 1000 students per month during the academic year. Unfortunately, every missed appointment potentially denies a fellow student the opportunity to receive the care that he or she seeks. The no show-cancellation policy and corresponding fee schedule is implemented as part of our continuing efforts to improve the delivery of quality and available healthcare for Pacific students.

No Show-Cancellation Policy: All appointments must be cancelled at least 24 hours in advance. Students who do not cancel at least 24 hours in advance will be charged according to the following nonnegotiable fee schedule:

\$50.00 for a specialty visit with internal medicine, psychiatry, or registered dietician

\$25.00 for a health appointment with a nurse practitioner or physician's assistant

\$25.00 for a counseling appointment with a psychotherapist

Health Services Rebuttal Policy: If a student feels he/she was mistakenly charged, the student must submit his/her rebuttal in writing to the Health Services Director. The Health Services Director will review the rebuttal and make the final decision on the matter. If a refund is deemed appropriate, the refund will be given in the same method as the payment.

Counseling Services Policy: If a student does not show up for two counseling appointments, that student will not only be charged according to the above fee schedule but also must obtain clearance from the psychotherapist to schedule another appointment.

Signed Consent: My signature below signifies that I have read, understood, and agreed to the above policy and fee schedule. I also authorize the Cowell Wellness Center to bill my student account in order to collect all fees incurred in accordance to the above terms.

Signature

Please Print Name

Date of Signature

Student ID Number

Meningococcal Disease



Are College Students At Increased Risk?

Overall, undergraduate students have lower risk than a non-student population (1.4 cases per 100,000 people per year). However, college freshmen living in dormitories have a modestly increased rate (4.6 cases per 100,000 people per year). Reasons for this increase are not fully understood, but are probably related to living in close proximity to each other.

How Are Meningococcal Bacteria Spread?

The bacteria are transmitted from person-to-person in secretions from the nose and throat. They are not spread by casual contact or by simply breathing the air near an infected person, but require close contact. The bacteria can live outside the body for only a few minutes; so if the germs contaminate a desk or book, they soon die and won't infect a person who touches it later.

As many as 2 in 10 people carry the bacteria in the back of the nose and throat at any given time, especially in winter. Why only a very small number of those who have the bacteria in their nose and throat develop disease, while others remain healthy, is not understood.

What Is Meningococcal Disease?

Meningococcal disease is caused by *Neisseria meningitidis* bacteria. The two most common forms of meningococcal disease are meningitis, a bacterial infection of the fluid and covering of the spinal cord and brain; or septicemia, an infection of the bloodstream. Meningitis has other causes as well, the most common being viral infection.

How Common Is Meningococcal Disease?

Meningococcal disease is uncommon. In the US, each year there are about 2500 cases (1-2 cases for every 100,000 people), with 300 to 400 occurring in California. Of 14 million students enrolled in colleges nationwide, approximately 100 acquire meningococcal disease each year.

How Is It Diagnosed?

A diagnosis is commonly made by growing the bacteria from the spinal fluid or blood. Identifying the bacteria is important for selecting the best antibiotics.

How Can I Avoid Getting Meningococcal Disease?

You can protect yourself by maintaining good health and hygiene. As a general recommendation, you should wash your hands frequently. Avoid sharing materials that make mouth contact, such as eating utensils, bottles, cigarettes, or lip balm. Contact a healthcare provider immediately if you are in close contact with someone who is known or suspected to have meningococcal infection.

Is The Vaccine Recommended For College Students?

Currently, the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices and the American Academy of Pediatrics do not recommend routine meningococcal vaccination for college students (even in dormitories). Meningococcal vaccination is recommended for persons at above-average risk for meningococcal disease, including persons with certain immune system problems, those lacking a spleen, and travelers to countries where meningococcal disease is common. It should be considered for college freshmen who will live in dormitories. The vaccine is comprised of 4 strains of the bacteria, but does not include type B and other strains that account for nearly 50% of meningococcal cases in California. Protection lasts 3-5 years; boosters may **not** be as effective as the primary vaccination. Discuss the risks and benefits of vaccination with your health care provider.



READ, SIGN & RETURN:

California State Law mandates that this informative sheet be read and signed by all freshman students entering the University of the Pacific. This sheet must be returned to the Cowell Wellness Center by August 15, 2009.

What you need to know about MENINGITIS.

- Meningococcal disease is a serious illness caused by bacteria that infect the blood or membranes surrounding the brain and spinal cord. It can lead to brain damage, disability, and death.
- It is most common in infants and in people with certain medical conditions. College **freshman**, particularly those who live in **dorms**, have a modestly increased risk of getting the disease. About 100 Cases occur on college campuses in the U.S. each year, with 5-15 deaths.
- Common **symptoms** of meningitis include stiff neck, headache, and fever, sensitivity to light, sleepiness, confusion, and seizures.
- It can be treated with antibiotics, but **treatment**, must be started early. Despite treatment, 10-15% of people who get the disease die from it. Another 10-20% suffer long-term consequences.
- A meningococcal **vaccine** is available from your doctor or college health service. It protects against four of the five most common types of this disease. Vaccine protection lasts 3-5 years and can prevent 50% - 70% of cases on college campuses.
- Meningococcal vaccine may cause **reactions** such as pain or fever. Discuss contraindications and rare but serious side effects with your health care provider.

Before you start college, Make sure you are up-to-date on all your immunizations: measles, mumps, rubella; tetanus, diphtheria; varicella; and hepatitis B.

Colleges and universities may require them for admission.

For more information check:

www.cdc.gov/ncidod/dbmd/diseaseinfo/meningococcal_g.htm

www.cdc.gov/nip/publications/VIS/default.htm

www.acha.org/info_resources

Ask your health care provider or student health service!

Freshman Students & Students in On-Campus Housing:

I have reviewed this information and...

I received the meningococcal vaccine and the vaccination date is on my immunization history form.

I intend to receive the meningococcal vaccine.

I do not intend to receive the meningococcal vaccine.

____ - ____ - ____
Pacific Student ID #

Printed Name

____/____/____
Birthdate

Signature

____/____/____
Date of Signature

Form Filed in medical chart



**CONSENT FOR MEDICAL TREATMENT OF MINORS
(Students 17 years and younger at the time of acceptance)**

The undersigned parent or guardian of _____
Printed First and Last Name DOB

who is ____ years old, hereby authorizes the medical staff of the University of the Pacific Cowell Wellness Center, as agents for the undersigned to consent to any diagnostic procedure (including x-rays), to the administration of medical or surgical treatment, or to any hospital care when any or all of the foregoing is deemed advisable by the medical staff and rendered under the general supervision of a physician licensed under the provisions of the Medical Practice Act.

This authorization is given in advance of any specific diagnosis, treatment, or medical care being required, and pursuant to the provisions of Section 25.8 of the California Civil Code.

Date _____ Signature _____
(Parent or Guardian)

Student's Full Name _____ / _____
(Last Name) (First Name)

Address _____

Parent or Guardian's Phone Number:

Father/Guardian

Home: () _____ Bus: () _____ Cell: () _____

Fax: () _____

Mother/Guardian

Home: () _____ Bus: () _____ Cell: () _____

Fax: () _____

Student's Birth Date: _____ ID#: _____

Allergies: _____

Medications or Other Pertinent Medical Information: _____

Student's Physician: _____ Phone No.: _____

Fax/Written Consent: Telephonic Consent: Date: _____

CWC Staff: _____

Please Print

Filed in medical chart

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

NOTICE

University of the Pacific and many other organizations and individuals are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS

This authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing or refusing to sign this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan of which the patient is not already a member, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by the individual on his/her behalf, and delivered to the Privacy Officer, (209)946-2124, 3601 Pacific Ave, Stockton, CA 95211. The revocation will take effect when Pacific receives it, unless Pacific or others have already relied on it. Immediately upon receipt of a revocation from a student, the Privacy Officer will notify Cowell Wellness Center. Pacific must give you a copy of this Authorization. This information is for use only by the recipient named above. It can not be given to any other individual or agency without the patient's authorization.

Information: The patient must complete this form in its entirety in order for Cowell Wellness Center to release any medical information. The patient and/or requesting party must be specific as to the nature of the information he/she would like and the purpose for which this is requested. The patient is entitled to receive a copy of this release.

I authorize: **The Cowell Wellness Center – University of the Pacific**
(Name of Individual or Agency)

1041 Brookside Road, Stockton, CA 95211
(Complete Address – Street, City, State, and Zip Code)

To release to: **The Chair of the Pacific Crisis Response Team and appropriate designee(s).**
(Name of Individual or Agency)

3601 Pacific Avenue, Stockton, CA 95211
(Complete Address – Street, City, State, and Zip Code)

Records of my treatment for dates: **Starting with the first year of enrollment at Pacific through the completion of enrollment at Pacific.**

Please Release the following: (1) Lab Reports: **Immunity Titres**
(2) X-ray Reports/Films: **TB Chest X-Ray Clearance**

(3) Immunization Records: **Complete immunization record, including recommended vaccinations, screenings, treatments, and treatment plans.**

The specified information below for the purpose of: **Response to a campus or local infectious disease outbreak on behalf of my personal health and safety.**

This Authorization expires: **At the completion of enrollment at Pacific** and this information is for use only by the recipient(s) named above. It can not be given to any other individual or agency without the patient's authorization.

DATE: _____ (required) PACIFIC ID#: _____ (required) DATE OF BIRTH: _____ (required)

PATIENT'S SIGNATURE: _____ PRINTED NAME: _____ (required)

I decline to release any of the aforementioned medical information:

(Patient's Signature)

(FAX COPIES ARE NOT ACCEPTED)

MAIL-IN CHECK OFF LIST

- ✓ History & Physical and Immunization History – 3 pages
- ✓ Copy of immunization card and immunization lab reports
- ✓ Signed Authorization for Release & Assignment of Benefits
- ✓ Signed Patient Lab Service Policy
- ✓ Signed Acknowledgement of Receipt of Notice of Privacy Practices
- ✓ Signed Acknowledgement of No Show Cancellation Policy & Fee Schedule
- ✓ State of California Mandated Meningitis Informative Sheet
- ✓ Signed Consent for Medical Treatment of Minors (17yrs or younger)
- ✓ Crisis Response Team Release of Medical Information