Meningitis Information

Deadline: August 1 for fall term  December 1 for spring term

College students living in residence halls/campus housing are at increased risk for meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. The Pennsylvania House and Senate passed a law concerning resident students and vaccination against meningococcal meningitis. The law requires the Student Health Services to have documentation of either your vaccination or a signed statement declining the vaccine after having received information concerning the benefits of receiving the meningitis vaccine.

What is meningococcal disease?
Meningitis is rare. But when it strikes, this potentially fatal bacterial disease can lead to swelling of the membranes surrounding the brain and spinal cord and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

How is it spread?
How is it spread? The disease is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing or sharing items like utensils, cigarettes and drinking glasses.

What are the symptoms?
The early symptoms usually include fever, severe headaches, stiff neck, rash, nausea and vomiting (these can resemble the flu). The disease progresses rapidly, often within 12 hours, so students are urged to seek medical care immediately if they experience two or more of these symptoms at the same time.

Can meningitis be prevented?
Yes. A safe and effective vaccine (Menactra) is available to protect against four of the five most common strains of the disease. Adverse reactions to Menactra consist primarily of redness, swelling and pain at the injection site and rarely a fever. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals. It does not protect against viral meningitis.

For more information
To learn more about meningitis and the vaccine, visit the Centers for Disease Control and Prevention (CDC) at www.cdc.gov/ncidod/dbmd/diseaseinfo

Attention international students: The Menactra vaccine may be difficult to obtain outside the U.S. In order to process your housing, please select the second option below to decline the vaccine. When you arrive in the U.S. you may choose to obtain the vaccine if you wish.

Please check the statement that applies, sign, and return to the Student Health Services at Chatham University.

- I have received the meningitis vaccine on (date) _______________________
- I have read and understand the information about meningitis and I decline the meningitis vaccine due to a strong moral or religious conviction.
- My physician has recommended I not receive the vaccine due to  ___________________________________________ ________________________________________________________________________________________________

Student Name (please print) ___________________________________________________________________________
Signature of Student _________________________________________________________________________________
SSN or Student ID # _____________________________________ Date ______________________________________
Chatham University requests all international students to provide documentation of their immunizations. **Students will not be permitted to register for the following term after initial registration unless this form is completed.** In addition, a hold will be placed on the student’s account if not completed prior to arrival on campus. These forms must be mailed or faxed or scanned to the Student Health Services.

**Deadline:**
- **August 1** for fall term
- **December 1** for spring term

**PART I**

Name _____________________________________________________________________________________________

Address ___________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Date of birth (mm/dd/yyyy) _______________ First semester at Chatham (month/year) _______________

Status:  ☐ Undergraduate  ☐ Graduate  ☐ Exchange student  ☐ English Language Program
 ☐ Full-time  ☐ Part-time  ☐ Resident  ☐ Commuter

**PART II**

To be completed and signed by your healthcare provider. **All information must be in English.**

**Required Vaccines**

1. M.M.R. (Measles, Mumps, Rubella) **Two doses of MMR are required.**
   
   Dose 1  ________________________________  Dose 2  ________________________________

2. Meningitis (Menactra or A,C,Y,W-135/ One dose-for all college first year students residing in dormitories/residence halls/Chatham apartments) _______________

   **This is required by Pennsylvania State Law. You may waive this vaccine. Please sign the waiver form if you are residing in Chatham residence halls.**

3. Hepatitis B (Three doses of vaccine, a positive hepatitis B surface antibody blood test or the start of the series prior to arrival on campus.)

   Dose 1  ______/______/_______  Dose 2  ______/______/_______  Dose 3  ______/______/_______

   or

   Hepatitis B surface antibody ______/______/_______  Result:  ☐ Reactive  ☐ Non-Reactive

**International Students are required to have a tuberculosis skin test prior to entering Chatham University regardless of BCG vaccine. The test must be performed no more than one year before starting at Chatham University.**

**Tuberculosis**

PPD Skin Test date ______/______/_______  (must have been performed after August 18, 2013)

Result:  ☐ Negative – no additional action needed

   ☐ Positive – chest x-ray required. Date of x-ray (mm/dd/yyyy) ___________________________________

   Result of x-ray ____________________________________________________________________________

continued on back
**Recommended Vaccines**

1. **Varicella (Chickenpox)**
   - Dose 1: ___________________________ month/day/year
   - Dose 2: ___________________________ month/day/year
   - Or date of illness: ___________________________ Year

2. **Tdap (Tetanus, Diphtheria, Pertussis) or booster of TD within last 10 years**
   - One dose date: ___________________________ month/day/year
   - Or TD booster date: ___________________________ month/day/year

3. **Hepatitis A (Two dose vaccine to complete series)**
   - Dose 1: ___________________________ month/day/year
   - Dose 2: ___________________________ month/day/year

4. **Polio (OPV/IPV)**
   - Primary series completed: ___________________________ month/day/year

---

**Health Care Provider**

Name (print)______________________________________________________________

Address______________________________________________________________

Signature__________________________________________ Phone_________________________