

**RETURN COMPLETED FORM, COPY OF SHOT RECORDS, AND COPY OF INSURANCE CARD TO:**  
 WSC Student Health Services  
 Student Center Bldg - Room 104  
 1111 Main Street  
 Wayne, NE 68787  
 Phone: 402-375-7470  
 Fax: 402-375-7128  
 Email: studenthealth@wsc.edu  
 Office Use Only: Term: \_\_\_\_\_

Name \_\_\_\_\_ SS# \_\_\_\_\_  
(print) Last First Middle

Student ID \_\_\_\_\_ Gender: M F Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Email Address \_\_\_\_\_ Cell Phone \_\_\_\_\_ Semester Start Date (MM/YY) \_\_\_\_\_

Permanent Address \_\_\_\_\_

Emergency Contact Person to be notified:  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Health Insurance Information \*Please attach a photocopy of the front and back of insurance card if available.\*  
 Name of Policy Holder \_\_\_\_\_ Policy Holder's Birth Date \_\_\_\_\_ OR SS# of Policy Holder \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Immunization Records

➔ ➔ Students who fail to provide the required proof of immunizations and THIS completed health form during the first semester of admission WILL NOT be allowed to register for any of the following semesters until they are in compliance. ⬅ ⬅

**REQUIRED IMMUNIZATIONS \*ATTACH COPIES\***

All students born on or after January 1, 1957 must show immunity to Measles (Rubeola) by completing **ONE** of the following options:

- Show proof of **TWO MMR (Measles, Mumps and Rubella) vaccinations** given after 12 months of age and separated by at least one month.
- OR**
- Show proof of **Positive Blood Titer to Measles (Rubeola). ATTACH A COPY OF LAB RESULTS.**
- **INTERNATIONAL STUDENTS ONLY** must be screened for Tuberculosis: Tuberculin (TB) Skin Test must be done within 6 months of enrollment showing negative results. Positive TB results require a chest x-ray. **ATTACH COPY OF TESTING RESULTS AND/OR X-RAY REPORT.**

**RECOMMENDED IMMUNIZATIONS**

- Meningococcal
- Varicella Series (Chicken Pox)
- Hepatitis B Series
- Tetanus, Diphtheria, Pertussis (Tdap)
- Hepatitis A Series
- Human Papilloma Virus (HPV)

Personal History

**Check (✓) if you have/had:**

<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Urinary tract infections
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Depression/Anxiety
<input type="checkbox"/> Asthma	<input type="checkbox"/> Anemia	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Cancer
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Drug/Alcohol Problems	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Hearing/Speech impairment	<input type="checkbox"/> Tobacco Use
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Amputation or permanent impairment	<input type="checkbox"/> Other _____

Allergies Medication/Environmental/Food: Yes \_\_\_\_\_ No \_\_\_\_\_  
 If Yes, list \_\_\_\_\_

Medications List prescription medication(s) you take \_\_\_\_\_

To the best of my knowledge, the above information is accurate. Permission is hereby granted to treat the above student as deemed necessary by the staff of WSC Student Health Office, Providence Medical Center (Wayne Hospital), Wayne Family Medicine, and Midtown Health Center. Effective treatment for students may require a consultative, collaborative effort between the above named facilities. I give permission for the exchange of medical/health related information to be used amongst the above named facilities in the coordination of treatment and to process insurance claims for benefits. Information contained in this health form will become part of your confidential medical record and cannot be released to friends, family members, etc. without your knowledge and written consent. (According to the Family Educational Rights and Privacy Act-copy available upon request.) Hard copy records, including immunization records, are kept on file during the student's enrollment at WSC and are archived for 10 years.

First Name \_\_\_\_\_  
Last Name \_\_\_\_\_

# WAYNE STATE COLLEGE

## MENINGITIS INFORMATION SHEET

To reduce the spread of bacterial meningitis among the student population, Wayne State College strongly recommends all incoming students residing in residence halls or living in other forms of group housing to get vaccinated. Wayne State College encourages all other students to consider vaccination as well. It is important for all students to become knowledgeable about meningitis and its symptoms in order to reduce personal risk. Please contact your local healthcare provider or immunization clinic about acquiring this immunization. For more information on meningococcal disease visit the Centers for Disease Control and Prevention Web site at [www.cdc.gov/meningitis/index.html](http://www.cdc.gov/meningitis/index.html) or the American College Health Association Web site at [www.acha.org/ACHA/Resources/Topics/Meningitis.aspx](http://www.acha.org/ACHA/Resources/Topics/Meningitis.aspx)

### What is meningococcal meningitis?

Meningococcal meningitis is a severe bacterial infection of the bloodstream and meninges (a thin lining covering the brain and spinal cord). It is a relatively rare disease and usually occurs as a single isolated event. Cluster of cases or outbreaks are also possible.

### Who gets meningococcal meningitis?

Anyone can get meningococcal meningitis, but it is more common in infants, children, and young adults. Also, college freshmen who live in residence halls have a slightly higher risk of getting this infection than others their age.

### How is the germ that causes this type of meningitis spread?

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

### What are the symptoms?

Although most people exposed to the meningococcus germ do not become seriously ill, some may develop fever, headache, vomiting, stiff neck, and a rash. Up to 25 percent of patients who recover may have permanent damage to the nervous system. The disease occasionally causes death.

### How soon do the symptoms appear?

The symptoms may appear two to 10 days after exposure, but usually within five days.

### When and for how long is an infected person able to spread the disease?

From the time a person is first infected until the germ is no longer present in discharges from the nose and throat, he or she may transmit the disease. The duration varies among individuals and with the treatment used.

### What is the treatment for meningococcal meningitis?

Certain antibiotics are very effective in eliminating the germ from the nose and throat. Penicillin is the drug of choice for meningitis.

### Should people who have been in contact with a diagnosed case of meningococcal meningitis be treated?

Only people who have been in close contact (household members, intimate contacts, health care personnel performing mouth-to-mouth resuscitation, day care center playmates, etc.) need to be considered for preventative treatment. Such people are usually advised to obtain a prescription for rifampin from their physician. Casual contact, as might occur in a regular classroom, office, or factory setting is not usually significant enough to cause concern. People who think they have been exposed to meningococcal infections should contact their local health department to discuss whether they should receive preventative treatment.

### Is there a vaccine to prevent meningococcal meningitis?

Presently, there are two vaccines that will protect against several of the strains of the meningococcus germ.

### STUDENT'S NAME-PLEASE PRINT LEGIBLY \_\_\_\_\_

My signature below signifies that I have received and read the material provided to me on meningitis by Wayne State College.

\_\_\_\_\_  
(Signature of Student) - **REQUIRED**

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Signature of Parent/Guardian, if student is younger than 19 years of age)

**IMPORTANT:** THIS COMPLETED FORM MUST BE RETURNED TO THE STUDENT HEALTH OFFICE IN ORDER TO REGISTER AND ATTEND CLASSES! More information about WSC Student Health Services can be viewed at: [wsc.edu/student-health](http://wsc.edu/student-health)

- I have already received the meningitis vaccination.  
Date vaccine received: \_\_\_\_\_
- I do **NOT** wish to get the meningitis vaccination.
- I will be receiving the meningitis vaccination in the future prior to attending WSC.

**\*\*\*\*REMINDER - RETURN THIS SHEET TO THE WSC STUDENT HEALTH OFFICE\*\*\*\***