



UNIVERSITY HEALTH SERVICE ACADEMIC YEAR 2008-2009

Dear International Student:

Congratulations and welcome to Central Connecticut State University.
Here is a list of the health requirements for the University:

Confidential Medical Form: Enclosed please find the form which includes a health history, immunization record and physical examination. PLEASE COMPLETE THE FORM AND MAIL (address listed on the front page of the Health form) no later than two weeks before the start of the semester.

The information provided on the Connecticut State University Health Service form is strictly confidential and will be reviewed and used only by health care providers employed by and affiliated with Central Connecticut State University. The information contained within the health form is not shared with any staff person within the CCSU Center for International Education, U.S. immigration officials nor any other person at the University without your written permission to release any part of the information on the form from the University Health Service.

Tuberculosis Risk Questionnaire: ("part D" of our health form which is on 3rd page) If the answer to any of the questions # 1 through 4 is YES, you are required to have a Tuberculin Skin Test. THIS SKIN TEST MUST BE PERFORMED IN AN AMERICAN FACILITY. It is available in our Health Service. It must be done within the first two weeks of the start of the semester if you have it administered in our health service.

On-Campus Housing Requirements: All students living on-campus are required to have the vaccine named "MENACTRA" for the prevention of Meningococcal disease. This vaccine must include the combination of the disease subtypes A, C, Y and W-135. This combination vaccine may not be available to you in your country. It is available in our Health Service.

Health Insurance Policy: All Central Connecticut State University students are required to maintain a health insurance policy that meets or exceeds the coverage provided by the ChickeringGroup/Aetna Health Insurance policy offered by the University. While you may waive this policy by providing proof of alternate health insurance coverage, please be aware that MANY healthcare providers (physician and medical facilities) in the local area surrounding the University may not accept your form of alternate health insurance coverage, leaving you personally responsible for your medical bills or refusing to see you (even if you can afford to pay at the time of the visit). Therefore, the Center for International Education and University Health Services strongly encourage all international students to purchase the Chickering/Aetna policy offered through the University.

Once you have arrived at the University, those of you who need the tuberculin skin test and/or Menactra vaccination can schedule an appointment at our office by calling (860) 832-1926.

Tuberculin Skin Test:	\$10.00 charge in our office
Menactra Vaccine:	\$21.00 charge in our office.

We encourage you to read our website at <http://www.ccsu.edu/healthservice> for more information about our department.

I look forward to meeting you during the International Orientation day scheduled before the semester begins. Prior to your arrival in the United States, please email me at zapatkap@ccsu.edu with any health related questions about the health form or medical concerns.

Again, I wish you a wonderful experience in America and especially at the University.

Sincerely,

Patricia Zapatka RN-C

PLEASE RETURN TO THE APPROPRIATE UNIVERSITY HEALTH SERVICE:

Central Connecticut State University
University Health Service,
1615 Stanley Street
New Britain, CT 06050
860/832-1925 Fax 860/832-2579

Eastern Connecticut State University
University Health Service
185 Birch Street
Willimantic, CT 06226
860/465-5263 Fax 860/465-4560

Southern Connecticut State University
University Health Service,
501 Crescent Street
New Haven, CT 06515
203/392-6300 Fax 203/392-6301
Western Connecticut State University

University Health Service
181 White Street
Danbury, CT 06810
203/837-8594 Fax 203/ 837-8583

Connecticut State University Health Service
Confidential Health Form

PLEASE MAKE A COPY OF THIS FORM BEFORE SUBMITTING IT TO THE UNIVERSITY HEALTH SERVICE.

PLEASE USE ATTACHED GUIDELINES FOR COMPLETING THE MEDICAL FORM

THE CSU HEALTH FORM IS REQUIRED TO BE COMPLETED PRIOR TO REGISTRATION.

Parts A, B, and C are to be completed by the student prior to being examined by the physician, a nurse practitioner or physician assistant.

Entering semester: [] Fall [] Spring year: [] 20 ____

PART A

Form with fields for: LAST NAME, FIRST NAME, SOCIAL SECURITY #, BIRTH DATE, BIRTH PLACE, HOME PHONE, PERMANENT HOME ADDRESS, STUDENT CELL PHONE, FATHER'S LAST, FIRST NAME, PHONE #, MOTHER'S LAST, FIRST NAME, PHONE #, GUARDIAN'S LAST, FIRST NAME, PHONE #, SPOUSE/PARTNER LAST, FIRST NAME, PHONE #.

PART B: IMMUNIZATION HISTORY

Form with fields for: DIPHTHERIA/PERTUSSIS/TETANUS, POLIO SERIES, MMR # 1 AND # 2, MENINGOCOCCAL VACCINE, HEPATITIS B SERIES, VARICELLA.

PART C: REVIEW OF SYSTEMS

If you have had any of the following, please check 'yes'. Explain YES answers in the space provided.

	Yes		Yes		Yes		Yes		
SKIN		RESPIRATORY		GENITOURINARY		MUSCULOSKELETAL		ENDOCRINE	
Acne		Asthma		Urinary Tract Infections		Arthritis		Diabetes	
Other Skin Problems		Chronic Cough		Kidney Stones or Disease		Fractures or Dislocations		Sudden Weight Change	
EYES		Bronchitis or Pneumonia		Sexually Transmitted Infection		Back/ Disc Problems		Overweight	
Blindness		Do you smoke?		Women:		Scoliosis		Thyroid Problems/Disease	
Eye Injury/Disease		CARDIAC		Menstrual Irregularity		Disease of the Joints		HEMATOLOGIC	
Wears Contacts/Glasses		High Blood Pressure		Disabled By Cramps		Paralysis		Easy Bruising	
Color Blindness		High Cholesterol		Abnormal Pap Smear		NEUROLOGICAL		Anemia/ low iron	
EARS/NOSE/THROAT		Irregular Heart Rate		PMS		Migraines		Sickle Cell Trait/Disease	
Hearing Loss/ Deafness		Heart Murmur		Breast Problems		Frequent Headaches		Clotting Disorder	
Frequent Ear Infections		History of Palpitations		Breast Surgery		Concussion		INFECTIOUS DISEASE	
Perforated Eardrum		Chest Pain		Pelvic Inflammatory Disease		Severe Head Injury		Chicken Pox	
Repeated Nosebleeds		GASTROINTESTINAL		Gyn Surgery		Dizziness/Fainting		Mononucleosis	
Sinus Infections		Stomach Problems/ Ulcer		Men:		Insomnia		Whooping Cough	
Frequent Sore Throats		Requires Special Diet		Epididymitis		Neuromuscular Disorder		Malaria	
Tonsils/Adenoids Surgery		Hepatitis		Testicular Torsion		Seizures/Epilepsy		Meningitis	
DENTAL		Gallbladder Problems		Loss/Damaged Testicle		MENTAL HEALTH		HOSPITALIZATION/ SURGERY	
Bleeding Gums		Irritable Bowel Problems		Undescended Testicle		Anxiety Disorder		OTHER PROBLEMS	
Poor teeth		Hemorrhoid Problems		Testicular Cancer		Clinical Depression			
Wisdom Teeth Extraction		Appendectomy				Anorexia and/or Bulimia			
		Hernia				Suicide Attempt			

DESCRIBE details for each 'yes' with dates. Please use an extra page if space is not adequate

CURRENT MEDICATIONS		ALLERGIES: No known drug allergies. List allergy and describe reaction that occurs
NAME	DOSAGE AND DOSING SCHEDULE	
_____	_____	Medication Allergy _____
_____	_____	Environmental/ Seasonal Allergy _____
_____	_____	Insect or Bee Allergy: _____
_____	_____	Food Allergy: _____

FAMILY HISTORY If you are adopted and do not know your family's medical history, please check here _____.

Relationship	age	health good/ poor	Age at Death	Cause of death	Alcoholism	Allergies/Asthma	Anemia/Bleeding disorder	Arthritis	Cancer	Diabetes	Eating disorders	Epilepsy/Seizure disorder	Emotional/mental disease	Genetic disorder	Heart disease	High Blood pressure	Kidney/bladder problem	Migraines	Neurological disorder	Suicide or attempt	Stomach disease	Stroke	Tuberculosis	
FATHER																								
MOTHER																								
SIBLING																								
SIBLING																								
SIBLING																								

SIGNATURES REQUIRED:

- I certify to the best of my knowledge that the information on this form is complete and correct.

STUDENT NAME (PLEASE PRINT) _____

STUDENT SIGNATURE: _____ DATE ____/____/____

- I consent to medical treatment by the University Health Service.

STUDENT SIGNATURE (18 YEARS OLD OR OLDER) _____ DATE: ____/____/____

CONSENT FOR MINOR (UNDER 18 YEARS OF AGE): I give my permission for medical treatment for my daughter/son if accident/illness should occur while she/he is a student at a Connecticut State University System campus. This would include referral to a local hospital which may result in her/his hospitalization, anesthesia, and surgery should it be necessary and I am unable to be reached.

PARENT/ GUARDIAN'S NAME (PLEASE PRINT) _____ RELATIONSHIP _____

SIGNATURE OF PARENT/GUARDIAN _____ DATE ____/____/____

PART D: TUBERCULOSIS (TB) RISK ASSESSMENT:**SECTION I: TO BE FILLED OUT BY THE STUDENT; SECTION II: TO BE FILLED OUT BY THE HEALTH CARE PROVIDER.****SECTION I:** *Student to answer the following questions:*

	YES	NO
1. To the best of your knowledge, have you ever had close contact with anyone who was sick with tuberculosis (TB)?		
2. Were you born in one of the countries listed below?		
3. Have you traveled or lived <u>for more than one month</u> in one or more of the countries listed below?		
4. Do you have Diabetes, Kidney Disease, Immunocompromised Diseases including HIV/AIDS, Silicosis, chronic steroid therapy or a history of the following: substance abuse, cancer, pulmonary fibrotic lesions on x-ray, Gastrectomy or Jejunoileal bypass surgery?		
5. Have you ever had a positive tuberculosis skin test in the United States?		

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB)

Afghanistan, Angola, Armenia, Azerbaijan, Bahamas, Bahrain, Bangladesh, Belarus, Benin, Bhutan, Bolivia, Bosnia-Herzegovina, Botswana, Brazil, Brunei, Darussalam, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Rep., Chad, China -Hong Kong SAR, China -Macao SAR, Columbia, Comoros, Congo, DR, Cote d'Ivoire, Croatia, Djibouti, Dominican Rep., Ecuador, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Gabon, Gambia, Georgia, Ghana, Guam, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, Hungary, India, Indonesia, Iran, Iraq, Japan, Kazakhstan, Kenya, Kiribati, Korea, DPR, Korea, Rep., Kyrgyzstan, Lao PDR, Latvia, Lesotho, Liberia, Lithuania, Macedonia, TFYR, Madagascar, Malawi, Maldives, Mali, Marshall Islands, Mauritania, Mauritius, Mexico, Micronesia, Moldova Rep., Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nepal, New Caledonia, Nicaragua, Niger, Nigeria, Northern Mariana Islands, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Romania, Russian Federation, Rwanda, Sao Tome & Principe, Saudi Arabia, Senegal, Serbia & Montenegro, Seychelles, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, Sri Lanka, Sudan, Suriname, Swaziland, Syrian Arab Rep., Taiwan, Tajikistan, Tanzania UR, Thailand, Timor-Leste, Togo, Turkey, Turkmenistan, Uganda, Ukraine, Uzbekistan, Vanuatu, Venezuela, Vietnam, Yemen, Zambia, Zimbabwe.

World Health Organization. Global Tuberculosis control. WHO report 2003.

SECTION II: TO BE FILLED OUT BY THE HEALTH CARE PROVIDER *Tuberculosis (TB) Testing Evaluation:*

- **IF THE ANSWER IS YES** to questions 1-4 above, the CSU System requires that a healthcare provider complete the TB testing evaluation below within 6 months prior to the start of classes. If the PPD skin test is positive, a chest x-ray is required and must be done within 6 months prior to the start of classes.

Question # 5: If your patient has had a previous positive PPD and answered YES to question # 5 above:

1. A new PPD is not required.
2. A chest x-ray is required and results are submitted in the appropriate box below.
3. If the student has been treated or is undergoing treatment, please complete the treatment section below.

- **IF THE ANSWER IS NO** to all of the above questions, no TB testing or further action is required and the section below DOES NOT need to be completed.

NOTE: *Previous BCG vaccine does not exempt the student from this requirement and a chest x-ray is not an acceptable substitute for a PPD (MANTOUX Skin Test).***FOR INTERNATIONAL STUDENTS – TUBERCULIN SKIN TESTING MUST BE DONE IN OUR UNIVERSITY HEALTH OFFICE or ANOTHER UNITED STATES MEDICAL FACILITY.****Tuberculin Skin Test: Use 5TU Mantoux test only. Multiple puncture test such as Tine is not accepted.**

Date Planted: ____/____/____	Date Read: ____/____/____	RESULT: (after 48-72 hours): _____ mm induration If no induration, please put "0" mm INTERPRETATION: ___ POSITIVE ___ NEGATIVE Read by: _____ (signature)
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IF TB SKIN TEST POSITIVE- (currently or in the past) A CHEST X-Ray is required

Chest x-ray: ___Normal ___Abnormal – please describe	Date of x-ray:
Treatment: No _____ Yes _____ (drug, dose, frequency, dates, location)	

PART E: This page to be completed by the student's HEALTH CARE PROVIDER.

A PHYSICAL EXAMINATION REQUIRED WITHIN ONE YEAR PRIOR TO ENROLLMENT AT THE UNIVERSITY

STUDENT NAME: _____ DATE OF BIRTH: _____
 NAME OF STUDENT (PRINT)

WGT. _____ HT. _____ BP _____ P _____

VISION: RIGHT 20/ _____ LEFT 20/ _____ WITH GLASSES: RIGHT 20/ _____ LEFT 20/ _____

HEARING: RIGHT _____ LEFT _____ METHOD USED _____

SYSTEM	NORMAL	DESCRIBE IF ABNORMAL
GENERAL APPEARANCE		
SKIN		
HEENT		
NECK, THYROID		
CHEST, BREASTS		
LUNGS		
HEART		
ABDOMEN		
GENITOURINARY		
MUSCULOSKELETAL		
LYMPHATIC		
NEUROLOGICAL		
PSYCHOLOGICAL		

If clinically indicated from history or physical exam; required for Division I athletes
DATE
URINALYSIS
SP. GR:
Glucose:
Protein:
Micro:
DATE :
HGB/HCT

TUBERCULOSIS SCREENING: PLEASE SEE PART "D" SECTION II FOR SCREENING GUIDELINES.

LIST ALL ALLERGIES (INCLUDING MEDICATIONS, INSECT VENOM, ETC.) _____

COMMENT ON TYPE OF REACTION (I.E. RASH, URTICARIA, ANAPHYLAXIS) _____

LIST ALL MEDICATIONS CURRENTLY BEING TAKEN _____

COMMENT ON SPECIAL DIETARY REQUIREMENTS _____

STATUS OF STUDENT'S PHYSICAL RESTRICTIONS UNRESTRICTED PARTIAL RESTRICTION FULL RESTRICTION

COMMENT _____

STATUS OF STUDENT'S HEALTH EXCELLENT GOOD POOR COMMENT _____

PRINT: HEALTH PROVIDER'S NAME _____ TELEPHONE # (____) _____ - _____
LAST FIRST
ADDRESS _____ CITY STATE ZIP
STREET
HEALTH PROVIDER SIGNATURE _____ DATE OF EXAMINATION ____/____/____
(This medical certificate will be on file in the University Health Service)

GUIDELINES FOR THE CSU HEALTH FORM

STUDENT SECTIONS OF THE MEDICAL FORM:

- **Parts A and C:** These sections to be filled out by student. Please complete part 'C' before your physical exam so that your health care provider can review this section with you.
- **Part D:** There are two sections to this page. Section I is to be filled out by the student. All students must complete the tuberculosis screening process. Please go to this section of the health form for further instructions.

NOTE: INTERNATIONAL STUDENTS – TUBERCULIN SKIN TESTING (PPD) RESULTS WILL ONLY BE ACCEPTED IF DONE AT OUR OFFICE OR AT ANOTHER UNITED STATES FACILITY.

HEALTH PROVIDER SECTION OF THE FORM:

- **Part D:** Section II of this part is to be filled out by the student's health provider.
- **Part E:** To be filled out by the student's health care provider. A PHYSICAL EXAMINATION must be done within a year prior to entering our University.

INFORMATION FOR THE IMMUNIZATION PORTION OF THE FORM

If there are minor differences in our guidelines from your state, you must comply with our requirements.

- **Part B: IMMUNIZATIONS:** Please provide the dates of the immunizations listed in this section. If there are minor differences in our guidelines from your high school or state, please follow our requirements outlined below.
 1. **Tetanus** Immunizations – list the childhood series. Tetanus booster (Td) – required within the past 10 years.
 2. **Polio** Immunizations – list the childhood series.
 3. **MMR –(MEASLES, MUMPS, RUBELLA)** The combination trivalent vaccine may be listed in the appropriate spaces provided.
 4. **Rubeola (Measles) Two vaccines** – Required by Connecticut State law. (This immunization is included in the MMR vaccine.)
 - a. **First Measles Vaccination** – on or after student's first birthday AND given after January 1, 1969.
 - b. **Second Measles Vaccination** – on or after January 1, 1980.

Please note:

 - If you did not receive your first measles shot in accordance with the guidelines, then two vaccinations must be administered after January 1, 1980 and no less than 30 days apart.
 - **If you have had Rubeola or Rubella as a child** or uncertain about immunity status, you must provide documentation of immunity from a blood test. We require a copy of this laboratory test to be submitted with the health form.
 - **EXEMPTION for Rubeola:** A date or blood titer is not necessary if you were born before 1957.
 5. **Rubella (German Measles) Vaccination** – one dose given on or after the student's first birthday. Required by Connecticut State law. (This immunization is included in the MMR vaccine.)
 6. **Meningococcal ("Meningitis") Vaccine** – required by Connecticut state law for all students living in campus housing but recommended for all incoming students. A student's housing assignment will be forfeited if Health Service does not receive proof of the meningitis vaccine by the first day of classes. Please see our website for more information on meningitis and the vaccine.
 7. **Hepatitis B Vaccination Series** – not required but strongly recommended. We offer any one or all doses at our health service to enable you to complete the series.
 8. **Varicella** (chickenpox) – please consider this vaccine if you have not had a history of chickenpox as a child.

The completed health form must be submitted prior to registration.

****IMPORTANT****
CONNECTICUT STATE LAW AND UNIVERSITY POLICY
MENACTRA VACCINE : THE "MENINGOCOCCAL VACCINE"
FOR MENINGITIS PREVENTION

NOW REQUIRED **FOR ALL THOSE LIVING IN THE RESIDENCE HALLS** AND HIGHLY RECOMMENDED FOR ANYONE UNDER THE AGE OF 25 YEARS OF AGE WHO IS NOT A CAMPUS RESIDENT. THIS MUST BE SUBMITTED AS PART OF YOUR **MEDICAL FORM** THAT IS **DUE** TO OUR OFFICE NO LATER THAN **07/15/08** OR **12/15/08 (SECOND SEMESTER)**. THIS IS A LATER SCHEDULE THAN FOR THE VARSITY ATHLETES.

DEAR PARENT/ GUARDIAN/ CENTRAL STUDENT:

As the college health service director at Central Connecticut State University, I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and a new recommendation from the Centers for Disease Control and Prevention (CDC).

On October 20,1999, the CDC's Advisory Committee on Immunization Practices (ACIP) voted to recommend that college students, particularly freshmen living in dormitories and residence halls, be educated about meningitis and the benefits of vaccination. The panel based its recommendation on recent studies showing that college students, particularly freshmen living in dormitories, have a sixfold increased risk for meningitis. The recommendation further states that information about the disease and vaccination is appropriate for other undergraduate students who also wish to reduce their risk for the disease.

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

Cases of meningitis among teens and young adults 15 to 24 years of age (the age of most college students) have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives. Between 100 and 125 meningitis cases occur on college campuses and as many as 15 students will die from the disease.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States — types A, C, Y and W-135. These types account for nearly two thirds of meningitis cases among college students in the United States.

I ENCOURAGE YOU AND YOUR CHILD TO LEARN MORE ABOUT MENINGITIS AND THE VACCINE. FOR MORE INFORMATION, PLEASE FEEL FREE TO CONTACT OUR HEALTH SERVICE AND/OR CONSULT YOUR CHILD'S PHYSICIAN.

Sincerely,

Myra Rosenstein, MD

Myra Rosenstein, MD
Medical Director
University Health Service

MENINGOCOCCAL DISEASE

What is Meningococcal Disease?

Meningococcal Disease is a rare but potentially life threatening bacterial infection that requires immediate treatment. The bacterium, *Neisseria meningitidis*, is the responsible germ which can manifest in one's body as meningitis (an inflammation of the thin lining of the brain and spinal cord), septicemia (blood poisoning) as well as arthritis and pneumonia.

Who can get meningococcal disease?

Anyone can get meningococcal meningitis, but it is more common in infants, children and young adults. The Center for Disease Control (CDC) surveillance reports over the last several years suggest increasing incidence of outbreaks on college campuses. Because of this, the American College Health Association (ACHA) recommends that colleges and universities inform all students about the availability of a safe, effective vaccine and provide access to the vaccine for those students who wish to be vaccinated against the disease. The CDC supports the decision of the ACHA to educate students and parents about this disease and the available access to the vaccine. Approximately 10% of the general population carries meningococcal bacteria in their noses and throats in a harmless state. The carrier state may last for days or months before it disappears spontaneously. These carriers who harbor the bacteria in their upper respiratory tracts (nose and throats) may have some protection against developing actual meningococcal disease.

Who is at risk for meningitis?

It is a relatively rare disease. Clusters of cases or outbreaks of meningococcal disease (three or more people with the same bacteria type causing the disease) have occurred. During an outbreak, the percentage of people carrying the bacteria may approach 95%, yet the percentage of people who actually develop meningococcal disease is less than 1%.

Students living in the confined environment of a college campus may have an increased risk for this disease. Data indicates that social behaviors, such as exposure to passive and active smoking, bar patronage and excessive alcohol consumption also increase students risk of getting the disease. Outbreaks usually occur in the late winter and early spring when school is in session.

What are the symptoms of meningitis?

The symptoms include sudden onset of fever, intense headache, nausea and often vomiting, stiff neck and frequently a rash. The symptoms may appear 1 to 10 days after exposure, but commonly less than 4 days after exposure.

How can I reduce the risk of getting the disease?

Meningococcal disease is spread through the exchange of nose or throat secretions via:

- Sharing the same drinking utensil (cup, bottle, glass, can or jug)
- Sharing the same mouthpiece of an instrument (trumpet, clarinet)
- Sharing the same eating utensil.
- Sharing the same cigarette, cigar etc.
- Sneezing or coughing in someone's face
- Sharing the same chapstick or lipstick
- Kissing.

How effective is the vaccine to prevent the disease?

The meningococcal vaccine has been shown to be safe and effective. The vaccine provides protection against serogroups A,C,Y,W-135, the most common strains of the disease. a majority of cases (75 percent) in the college age group are caused by Serotype C, which is included in the vaccine. Development of immunity post vaccination requires 7-10 days. The duration of the vaccine's efficacy is approximately three to five years.

Who should be vaccinated for the prevention of the disease?

Pre- exposure vaccination will enhance immunity to the bacteria that cause most strains of meningococcal disease.

For the college population, we recommend the following groups consider vaccination:

- Entering college students who elect to decrease their risk for meningococcal disease.
- The highest priority is among students age 18 - 24 years of age. Students older than 25 years have a lower risk of contracting the disease.
- Non pregnant persons 30 years or younger who request vaccination in order to decrease their risk for disease or who are at risk due to increased cases in their area.

What things should be done after receiving the vaccine?

The following simple treatments can help reduce the severity of any side effects you may experience:

- Drink eight to 12 glasses of water or fruit juice a day. Avoid alcohol during this period as they tend to increase the severity of the side effects.
- If you have any mild symptoms of body aches or fever, you may take Tylenol or Ibuprofen (Advil, Motrin) as directed on the packaging.
- To decrease arm soreness, apply ice to the area. You do not have to limit your activity if your arm is sore.
- **IF YOU FEEL YOU ARE HAVING A REACTION THAT IS MORE THAN THE NORMAL REACTION, PLEASE EITHER TELEPHONE US OR RETURN TO THE HEALTH SERVICE.**

Meningococcal disease is rare. However, anyone who becomes ill with mild flu like symptoms should watch for the sudden onset of increased fever (101 or greater) with headache, vomiting, rash or change in mental state. If any of these additional symptoms develop, do not delay in seeking medical attention. You can also find information about the disease [E.G. WEBSITE OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), WWW.CDC.GOV/NCIDOD/DBMD/DISEASEINFO, American College Health Association WEBSITE, WWW.ACHA.ORG].