MINOR - MEDICAL CONSENT & MENINGITIS SURVEY

Return this completed form along with IMMUNIZATION records via the Student Health Portal:
William Paterson University
Counseling, Health and Wellness Center
Phone # (973) 720-2360
For questions email wpuimmunization@wpunj.edu

**** TO BE COMPLETED BY THE PARENT OR GUARDIAN OF ALL STUDENTS AGE 17 OR YOUNGER ****

Student Name: _____ **Student ID#: 855**_____

Student DOB: _____ **Parent/Guardian Contact #:** (_____) _____

MENINGITIS SURVEY

If student is 18 years or older, DO NOT complete this form. Survey must be completed online via WP Connect Student Health Portal

New Jersey statutes require that all students be informed about meningitis disease, the effectiveness of the vaccines and the availability of immunization. The meningitis vaccine can be obtained through your private health care provider, local health departments or some pharmacies. The information is included with this form. After reading the enclosed information on meningitis and the meningitis vaccine please complete the following questionnaire and submit it with your immunization documentation.

Please Check One Box Below:

- ☐ I have *already received* the meningitis vaccine.
  (Please make sure you upload a copy of your vaccine record to WP Connect Student Health Portal)
- ☐ I have reviewed the information on meningitis and *intend* to receive the vaccine.
- ☐ I have reviewed the information on meningitis and *choose not to receive the vaccine.*
  (I understand I will not be permitted to live on campus without receiving the vaccine or uploading valid exemption document)

Parent/Guardian Name *(print)*: _____

Parent/Guardian Signature: _____ **Date:** _____

PARENTAL CONSENT FOR MEDICAL TREATMENT OF A MINOR

I hereby authorize the Counseling, Health and Wellness Center at William Paterson University to render any treatment or medical care deemed necessary for the health and safety of _____
Print Student's Name
and facilitate ambulance transport to a nearby hospital in the case of a medical emergency.

Parent/Guardian Signature: _____ **Date:** _____

Revised 5/28/2020

Do not return this page to us. Keep this page for your records.

MENINGITIS INFORMATION FOR STUDENTS & PARENT/GUARDIAN

MENINGITIS INFORMATION

New Jersey State law requires that colleges provide incoming students with information about meningitis infection and available vaccinations. In providing this information we want our William Paterson University students and parents to have the most up to date information regarding this devastating disease and methods of prevention.

The Disease Meningococcal meningitis is a bacterial infection that can have sudden onset and strike otherwise healthy people, it can cause permanent disability and death. Although it is rare, teens and young adults age 16 to 23 are at increased risk. College students who live and work in close proximity to each other are at particularly high risk. The infection can attack the lining of the brain and spinal cord and the bloodstream and cause flu like symptoms, which can make diagnosis difficult. Common symptoms are: confusion, fatigue, rash of dark purple spots, sensitivity to light, stiff neck, nausea, vomiting, headache and high fever. The rates of meningococcal disease have been declining in recent years in part to consistent vaccination. Even with the decline in cases, meningococcal meningitis continues to have a fatality rate of 10-15% so continued prevention is necessary to keep this disease at bay.

Prevention The best way to protect yourself is to get vaccinated. Currently two different types of meningitis vaccines are available. The first vaccine protects against four strains of meningococcal bacteria known as A,C,Y, W-135 (Menactra and Menveo and Menomune). The Advisory Committee on Immunization Practices (ACIP) recommends two doses for all adolescents. The first dose is typically given at 11 or 12 years old. Because the vaccine wanes in effectiveness a booster is recommended at age 16 so the adolescent has continued protection when they are at highest risk. This vaccine is mandatory for all students under the age of 19 and for those living in University housing (see page 4 for more information about requirements). A second vaccine protects against Meningitis type B. This vaccine is not mandatory for most students, however there have been outbreaks and individual cases of meningitis type B on college campuses in recent years. Teens and young adults **may** be vaccinated with the serogroup B vaccine (Bexsero or Trumenba). In June of 2015 the ACIP recommended that given the seriousness of meningococcal disease and the availability of a licensed vaccine, individuals are encouraged to consult with their healthcare provider regarding administration of this vaccine.

If you have more questions regarding vaccine recommendations you can visit our web site https://www.wpunj.edu/health-wellness/health-services/ or call us at 973-720-2360. You can also visit the Center for Disease Control website at cdc.gov/meningococcal/vaccine-info.html or American College Health Association website at acha.org.

MENINGOCOCCAL VACCINE REQUIREMENTS New Jersey law requires that new students enrolling in a public private institution of higher education in New Jersey to have received meningococcal vaccines as recommended by the Advisory Committee on Immunization Practices (ACIP). There are two types of meningococcal vaccines that might be required depending on your age and your risks: the meningococcal conjugate vaccine (MenACYW) that protects against serogroups A, C, Y, and W disease; and the meningococcal serogroup B vaccine (MenB) that protects against serogroup B disease.

MenACYW (Menactra® and **Menveo®)** vaccine is routinely recommended at ages 11-12 years with a booster at 16 years. Adolescents who receive their first dose of MenACWY vaccine on or after their 16th birthday do not need a booster dose. Additional doses may be recommended based on risk. People 19 years of age and older are not routinely recommended to receive the MenACYW vaccine unless they are students living in residential housing or if another risk factor applies.
MenB (Bexsero® and Trumenba®) vaccine is routinely recommended for people ages 10 years or older with high risk health conditions. People 16-23 years old (preferably at ages 16-18) may also choose to get a MenB vaccine.

AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

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1) **Purpose and Benefits.** The purpose of this form is to obtain consent to participate in telemedicine consultation to enable patients to get real-time access to a healthcare provider with the convenience of using a video chat on a smart phone, tablet, or computer.

2) **Nature of Telemedicine Consultation**: During the telemedicine consultation:
   a) Details of your medical history, examinations, x-rays, and tests will be discussed with other health professionals through the use of interactive video, audio and telecommunications technology.
   b) Physical examination may take place.
   c) Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.

3) **Medical Information and Records.** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Additionally, dissemination of any patient-identifiable images or information from this telemedicine interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.

4) **Confidentiality.** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. All existing confidentiality protections under federal and New Jersey State law apply to information disclosed during this telemedicine consultation.

5) **Risks and Consequences.** The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a healthcare provider at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to provider contact. Following the telemedicine consultation, your provider may recommend an in-person office visit or a local emergency room for further evaluation.

6) **Rights.** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right of future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the option to consult with the healthcare provider if you travel health center location within the office hours.

7) **Financial Agreement.** You have read and signed the Acknowledgment of Financial Responsibility and Insurance Authorization Consent Form which applies to telemedicine consultation.

I have been advised of all the potential risks, consequences and benefits of telemedicine. My health care practitioner has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above. I hereby give my informed consent for the use of telemedicine in my medical care.

Print Student Name:_____ **Student ID # 855**:_____

Student Signature:_____ **Date**:_____

Parent/Guardian Signature _____

(*Required only if the student is 17 years old or younger)*

WILLIAM PATERSON UNIVERSITY
COUNSELING, HEALTH & WELLNESS CENTER
OVERLOOK SOUTH
(973)-720-2360 · (973)-720-2257 · FAX: (973)-720-2632
300 POMPTON ROAD · WAYNE, NEW JERSEY 07470-2103 · WWW.WPUNJ.EDU

MEDICAL

CONSENT FOR TREATMENT & INSURANCE AUTHORIZATION

A) CONSENT FOR MEDICAL TREATMENT

I hereby consent to medical treatment as deemed necessary by The Counseling Health and Wellness Center (CHWC) providers, including routine health examinations, preventative measures, laboratory tests, administration of medications, any other diagnostic or therapeutic treatments, first aid and necessary referral to outside healthcare providers. My signature below indicates that I have had the chance to read the **NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES** AT CHWC. I understand that I may request a printed copy of this policy at any time.

B) ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

1) I understand that CHWC does not contract with all health insurers and it is my responsibility to know if my health insurance provides coverage for CHWC services or requires a referral or pre-approval for such services.
2) I understand that I am financially responsible to CHWC for any co-pays, deductibles and/or co-insurance not covered by my health insurance.
3) I understand that certain insurance plans (including but not limited to HMOs and EPOs) designate specific providers for my health care, and will not pay Counseling, Health and Wellness Center for services rendered. I understand the policy of my plan; I choose to receive services at CHWC, and I am aware that I am financially responsible to pay for the services that I receive at CHWC

C) **INSURANCE AUTHORIZATION (If your health insurance contracts with CHWC)**

1) I understand that Medical Healthcare Solutions (MHS) is contracted with CHWC to provide medical billing services.
2) I authorize MHS to apply for benefits on my behalf for the medical services rendered. I certify that the health insurance information I have provided to CHWC is true and accurate. I understand that if my health insurance information or coverage changes, I must notify CHWC
3) If I do not want my health insurance to be billed for the care rendered by CHWC, I understand that it is my obligation to notify the CHWC front office staff at the end of my visit and to complete a Self-Pay Request form. If I make this election, I understand that I will be responsible for payment in full for all charges for my care from CHWC.
4) I understand that MHS and/or my health insurance company may request and receive medical information about me if CHWC files a claim on my behalf. I also understand that the subscriber to my health insurance will be notified by my health insurer of the nature of these claims filed on my behalf. The subscriber is the person who is the primary policy holder for my health insurance (for example, my parent or spouse).
5) I understand that I may address any questions concerning my charges, coverage, billing or payments, to MHS at 1800-762-9800.

CONSENT TO A, B, C:

Student's Name _____ **Student ID# 855**_____
(Please Print)

Student's Signature _____ ***Date*** ____/_____/_____

Parent/Guardian's Signature _____ ***Date*** ____/_____/_____
(Required only if the student is 17 years old or younger)

CONSENT FOR MHS TO DISCUSS CLAIM INFORMATION/CHARGES WITH MY SUBSCRIBER/INSURANCE POLICY HOLDER

YES ☐

NO ☐

I authorize MHS staff to discuss insurance claim information (which may include diagnosis and treatment information) with the subscriber, the person named as the primary policy holder on my health insurance, and to my health insurance for a claim filed on my behalf. I understand that I have the right to revoke this authorization at any time. If I choose to revoke this authorization, I must do so in writing to The Counseling Health and Wellness Center, 300 Pompton Road, Wayne, NJ 07470. Unless revoked, this consent will be valid

Student's Name _____ **Student ID# 855**_____
(Please Print)

Student's Signature _____ ***Date*** ____/_____/_____

Parent/Guardian's Signature _____ ***Date*** ____/_____/_____
(Required only if the student is 17 years old or younger)

FOR OFFICE USE ONLY

Witness Signature _____ **Date:** _____

We attempted to obtain written consent for treatment and release but consent could not be obtained because:
_____ Individual refused to sign
_____ Communications barriers prohibited obtaining the consent.
_____ An emergency situation prevented us from obtaining consent
_____ Other (Please Specify) _____

Name/Signature of Office Staff: _____

WILLIAM PATERSON UNIVERSITY

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Acknowledgement of Receipt of Notice of Privacy Practices

My signature below acknowledges that I have had the chance to review the Notice of Privacy Practices and had the opportunity to ask any questions I have regarding the information in the notice.

I understand that I may have a printed copy of this document if I so wish and may ask questions about its content at any point during my treatment at the Counseling, Health, and Wellness Center.

Student's Name _____ **Student ID# 855**_____
(Please Print)

Student's Signature _____ **Date** _____

Parent/Guardian's Signature _____ ***Date*** _____
(Required only if the student is 17 years old or younger)

FOR OFFICE USE ONLY

Witness Signature _____ **Date:** _____

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
_____ Communications barriers prohibited obtaining the acknowledgement.
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please Specify) _____

Name/Signature of Office Staff: _____

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Student Athlete Request and Authorization to Release Records and/or Information

This form when completed and signed by you authorizes the Counseling, Health and Wellness Center and the Directors of Athletics, Athletic Coaches, Athletic Training Staff and Athletic training students, Directors of Club Sports, & Club Sports Advisors & Coaches, to release protected information from your clinical record to the person or agency you designate.

I authorize the Counseling, Health and Wellness Center clinical and administrative staff and the Directors of Athletics, Athletic Coaches, Athletic Training Staff and Athletic training students, Directors of Club Sports, & Club Sports Advisors & Coaches to release information to one another regarding my athletic physical and any relevant information related to participation in athletics & club sports at William Paterson University.

The records are to be discussed verbally, via fax, or via email for the purpose of coordination of care.

This authorization shall remain in effect for one year from the date indicated below or until (fill in expiration date/event): _____.

I understand that I have the right to revoke this authorization in writing, at any time by sending or delivering such written notification to the Counseling, Health and Wellness Center. However, my revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Print Name DOB

_____ _____
Signature of student/parent if minor Date

Revised 6/2/10