Quick Reference Guide– What is in This Document?

Minimum safety information that all university employees need to know

- How to report emergencies - dial 911 – from any telephone on or off campus.
- Work Order/Work Request
- UL Lafayette general safety rules
- An informational sheet on what to do if you have an accident
- A copy of an accident reporting form – entitled DA2000
- A copy of an accident reporting form – entitled DA3000
- Return to work policy statement
- A copy of the motor vehicle accident reporting form – DA2041 (keep this in your glove box)
- Bloodborne Pathogens information/Meningitis general information

Other Matters of Safety That You Need to Know

1. Environmental Health and Safety Website – (www.safety.louisiana.edu)
   - Safety policies
   - Supervisor responsibilities
   - Safety training classes with schedule
   - Safety forms (downloadable/editable)
   - Listing of departmental safety coordinators

2. Driver’s Safety Training – (Cornerstone on ULINK)
   - Training is mandatory for all employees who drive on university business
   - Travel Request documents require a training date for expenses relative to ground transportation

3. Violence in The Workplace Policy
   - If threatened or assaulted, report to either University Police or Human Resources

4. Employee Drug Testing Policy
   - Pre-employment, Post Accident, Random, Reasonable Suspicion, & Return-to-duty

5. Other Employee Policies of Interest
   - ADA Policy Statement
   - EEOC Policy Statement
   - Sexual Harassment Policy
   - Asbestos Management Plan – facilities.louisiana.edu/resource-center
   - Tobacco-Free Policy breathe - breatheeasy.louisiana.edu/
   - Return to Work/Transitional Work Duty - (contact Human Resources at 482-4246)
   - BEAP – Available online and updated annually (cornerstone training platform on ULINK)
   - General Campus Electrical Safety (Section 8.33): http://www.safety.louisiana.edu/sites/safety/files/General%20Safety%20around%20Electricity.pdf

   - Hurricane/Tropical Storm Preparedness, 3-phased plan
   - Pandemic Flu Preparedness, 4-phased plan
   - Emergency Notification System – ens.Louisiana.edu (cell phone text messages)
Contact Information for Emergencies and Unsafe Conditions

DIAL 911 FOR ALL EMERGENCIES

University Police are the First Responders for ALL Emergencies

Notice for University Employees Regarding Safe Work Practices

Good safe work ethics are required from every University employee. Any employee who repeatedly commits unsafe acts is a danger to himself or herself and to others around him or her. Once any unsafe condition is discovered, it should be reported to a Departmental Safety Coordinator or supervisor immediately. Departmental supervisors are responsible for initiating corrective action and for ensuring that all employees are trained on how to do these tasks safely.

Work Orders and Work Requests

Work Orders can be submitted by:

- Filling out the online work order form
- Emailing our office at workorder@louisiana.edu
  (Building name, Room number, Contact name & Phone number must be provided)
- Calling the Work Order Desk at 482-6440
- Filling out the work order form and mailing in through inter-office mail

For a Work Request (construction projects above regular maintenance):
- Please contact Facility Planning at 482-2001

For Pest Control (insects, rodents, etc.):
- Please contact Facility Management at 482-6441

For Elevator Problems (elevator cars not running, Doors not opening or closing, and leveling issues):
- Please contact the Work Order Desk at 482-6440
**Note: Please do not email elevator request**

Solid Waste Services (trash removal, dumpsters and recycling containers):
- Please contact Grounds Services at 482-6440

Hazardous Waste Disposal (used and unused chemical disposal & empty drums):
- Please contact the Safety Office at 482-1049 or 482-5357
UL Lafayette General Safety Rules

Note: These rules shall be distributed to every university employee as required by the Office of Risk Management. These rules shall also be available for students.

- Every employee is expected to take responsibility for his or her own safety.
- DO NOT knowingly put yourself in an unsafe working environment.
- Determine who your Departmental Safety Coordinator is – ask your supervisor if you are not sure.
- Report accidents or any unsafe activity to a Departmental Safety Coordinator or Supervisor.
- Possession or use of any weapons on campus is prohibited by law.
- UL Lafayette is an alcohol and drug free zone. Possession or use of these on campus is prohibited.
- Smoking is not allowed in any University building.
- Horseplay and fighting are not tolerated on campus.
- Notify your supervisor of any impairment that may reduce your ability to perform tasks in a safe manner.
- Operate equipment only if you are trained and authorized to do so.
- Use Personal Protective Equipment (safety glasses, ear protection, etc) to protect yourself from hazards.
- Keep an orderly work environment. Pay close attention to hazards that can cause slips, trips, or falls.
- Store flammables, hazardous materials, and hazardous waste in appropriate containers.
- Bend your knees when lifting objects. DO NOT bend your back when lifting objects.
- Fasten safety belts before starting any motor vehicle.
- Additional safety procedures and policies may be applicable for certain departments. Consult your Departmental Safety Coordinator or the EH & S Policy for more information on these. If you do not know who your Departmental Safety Coordinator is, contact the EH & S office at 482-1840.

Reference: UL Lafayette Environmental Health and Safety Policy, section 8.2
What to do if you have an accident...

For All Accidents (Including those involving a Motor Vehicle)

- Available on our website at all times (safety.louisiana.edu/report-issue/accident-campus)
- If necessary, dial 911 or report to an emergency medical center of your choice
- Contact your Departmental Safety Coordinator (safety.louisiana.edu/about-us/coordinators)
- For any employee injury, the DSC will complete ORM DA –2000 (keep copy for your records)
- For an injury to a NON-employee, the DSC will complete ORM DA –3000
- For an employee injury requiring medical attention (safety.louisiana.edu/report-issue/job-injury)
  1. Ask the medical provider to contact Wellness Works, 888-977-3319 (24 hours a day)
  2. The employee or the medical provider should also contact:
     Human Resources Department
     Martin Hall, room 170
     482-6242
     (This is for Worker’s Compensation paperwork)

Additional Information for Accidents Involving a Motor Vehicle

- Contact University Police or the Police Authority Having Jurisdiction - Dial 911
- Complete Form DA-2041 – Driver’s Accident Report Form
- Contact:
  Joey Pons
  Parker Hall, room 227
  482-5357
  safetyman@louisiana.edu

Return to Work Policy

The University follows a transitional return-to-work process when an employee is injured on the job and is released by a physician with restrictions that result in the inability of the employee to perform the full functions of their job. This effort is to provide for an employee’s earliest possible safe return to work for occupationally related injuries or illnesses, give employees more options in returning to work other than only being able to return with a full duty release, retain qualified employees within state government thus utilizing their training and expertise facilitate a safer working environment by taking more responsibility for injured employees, reduce medical costs of Worker’s Compensation claims due to extended work absences, and reduce the duration of time needed for employees to transition back to full duty.

The transitional return-to-work process is a collaborative effort between the employee, the employee's supervisor, the return to work coordinator (Human Resources) and the employee's treating physician(s). If the employee is eligible, he or she is given a modified job assignment for a specified time frame as determined by the physician(s).

Employees who have questions regarding this process can contact the Office of Human Resources at (337) 482-6242.
OFFICE OF RISK MANAGEMENT
UNIT OF RISK ANALYSIS AND LOSS PREVENTION
STATE EMPLOYEE INCIDENT/ACCIDENT INVESTIGATION FORM
Worker’s Compensation Claims—For Agency Use Only

(PLEASE TYPE OR PRINT)

1. AGENCY ____________________________

2. ACCIDENT DATE ________________ 3. REPORTING DATE ________________

4. EMPLOYEE NAME (LAST, FIRST) ________________________________________

5. JOB TITLE ____________________________________________________________

6. IMMEDIATE SUPERVISOR ______________________________________________

7. DESCRIBE IN DETAIL HOW INCIDENT/ACCIDENT OCCURRED (USE ADDITIONAL SHEET IF NECESSARY)
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

8. PARISH WHERE OCCURRED ____________________________ 9. PARISH OF DOMICILE __________

10. WAS MEDICAL TREATMENT REQUIRED _____ Y _____N

11. EXACT LOCATION WHERE EVENT OCCURRED ____________________________
    ________________________________________________________________
    ________________________________________________________________
    ________________________________________________________________
    ________________________________________________________________
    ________________________________________________________________
    ________________________________________________________________
    ________________________________________________________________
    ________________________________________________________________

12. NAME (S) OF WITNESSES ____________________________________________

13. NAME OF PERSON COMPLETING THIS SECTION OF REPORT ________________

14. SIGNATURE ____________________________ 15. DATE ________________

KEEP COMPLETED FORMS ON FILE AT THE LOCATION
WHERE INCIDENT/ACCIDENT OCCURRED

FORM DA 2000
REVISED 07/2014
This form is prepared for internal use only and is prepared in anticipation of litigation.
**Employee Post Incident/Accident Analysis (DA 2000)**

[Required for all incidents/accidents]

[This form is NOT for use in reporting a claim. The claim reporting form can be found at: www.laorm.com]

**MANAGEMENT SECTION**

16. NAME OF PERSON COMPLETING THIS SECTION OF REPORT ________________________________

17. POSITION/TITLE ________________________________________________________________

18. IS THE PERSON COMPLETING REPORT TRAINED IN ACCIDENT INVESTIGATION ______ Y ______ N

19. WAS EQUIPMENT INVOLVED ______ Y ______ N (If no, skip to question 20)
   A. TYPE OF EQUIPMENT ____________________________________________________________
   B. IS THERE A JSA FOR EQUIPMENT ______ Y ______ N
   C. DATE LAST JSA PERFORMED ________________

20. HAVE SIMILAR ACCIDENT INCIDENTS OCCURRED ______ Y ______ N

21. DID INCIDENT INVOLVE SAME INDIVIDUAL ______ Y ______ N

22. SAME LOCATION ______ Y ______ N

23. WAS THE SCENE VISITED DURING THE INVESTIGATION ______ Y ______ N
   A. DATE & TIME ________________
   B. ARE PICTURES AVAILABLE ______ Y ______ N
   C. IF NO, REASON FOR NOT VISITING ____________________________

**ROOT CAUSE ANALYSIS**

<table>
<thead>
<tr>
<th>UNSAFE ACT (PRIMARY):</th>
<th>☐ Failure to comply with policies/procedures</th>
<th>☐ Failure to use appropriate equipment/technique</th>
<th>☐ Inattention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Inadequate/lack of JSA/standards</td>
<td>☐ Incomplete or no policies/procedures</td>
<td>☐ Inadequate training</td>
</tr>
<tr>
<td></td>
<td>☐ Inadequate condition on policies/procedures</td>
<td>☐ Inadequate adherence of policies/procedures</td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td>__________________________________________</td>
<td>__________________________________________</td>
<td></td>
</tr>
</tbody>
</table>

Detailed explanation of checked box __________________________________________

**WHY WAS ACT COMMITTED:**

| UNSAFE CONDITION (PRIMARY): | ☐ Inappropriate equip/tool | ☐ Inadequate maintenance | ☐ Inadequate training | ☐ Wet surface |
|                            | ☐ Damaged/defective building component | ☐ Broken equipment | ☐ Inadequate guard | ☐ Electrical hazard | ☐ Fire Hazard |
|                            | ☐ Other (specify) | __________________________________________ | __________________________________________ |              |

Detailed explanation of checked box __________________________________________

**WHY DID CONDITION EXIST:**

**CONTRIBUTORY FACTORS (IF ANY):**

**IMMEDIATE ACTION TAKEN TO PREVENT RECURRENT:**

**LONG RANGE ACTION TO BE TAKEN:**

**WHAT ADDITIONAL ASSISTANCE IS NEEDED TO PREVENT RECURRENCE:**

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**KEEP COMPLETED FORMS ON FILE AT THE LOCATION WHERE INCIDENT/ACCIDENT OCCURRED**

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**FORM DA 2000**

**REVISED 07/2014**

This form is prepared for internal use only and is prepared in anticipation of litigation.
Visitor/Client Post Incident/Accident Analysis (DA 3000)
[This form is NOT for use in reporting a claim. The claim reporting form can be found at: www.laorm.com]

OFFICE OF RISK MANAGEMENT
UNIT OF RISK ANALYSIS AND LOSS PREVENTION
VISITOR/CLIENT ACCIDENT REPORTING FORM
General Liability Claim: – For Agency Use Only

KEEP COMPLETED FORMS ON FILE AT THE LOCATION
WHERE INCIDENT/ACCIDENT OCCURRED

(PLEASE TYPE OR PRINT)

1. AGENCY NAME and LOCATION CODE __________________________________________________________________

2. DATE and TIME of ACCIDENT __________________________________________________________________________

3. VISITOR/CLIENT NAME _______________________________________________________________________________

4. VISITOR/CLIENT ADDRESS _____________________________________________________________________________

5. CLAIMANT’S TELEPHONE # ___________________________________________________________________________

6. CLAIMANT DETAIL DESCRIPTION OF HOW ACCIDENT OCCURRED ____________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

7. DID THE EMPLOYEE ASK THE CLAIMANT IF HE/SHE WAS INJURED? _Y_ _N

8. DID THE CLAIMANT VERBALLY EXPRESS AN INJURY TO ANY PART OF HIS/HER BODY? _Y_ _N

9. IF THE CLAIMANT EXPRESSED AN INJURY, WHAT PART OF HIS/HER BODY DID THEY STATE WAS INJURED? PLEASE BE SPECIFIC (I.E. RIGHT FOREARM, LEFT WRIST, LOWER RIGHT ABDOMEN) ________________________________

_____________________________________________________________________________________________________

10. IF THE CLAIMANT EXPRESSED INJURY, WAS MEDICAL CARE OFFERED? _Y_ _N

11. DID THE CLAIMANT ACCEPT OR DECLINE MEDICAL CARE? _ACCEPT_ _DECLINE

12. WERE THERE WITNESS (ES) _Y_ _N

13. WITNESS’S NAME, ADDRESS, and TELEPHONE # (use additional sheet if needed)

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

14. WITNESS STATEMENTS ATTACHED _Y_ _N

This form is prepared for internal use only and is prepared in anticipation of litigation.
Visitor/Client Post Incident/Accident Analysis (DA 3000)

[This form is NOT for use in reporting a claim. The claim reporting form can be found at: www.laorm.com]

15. DETAIL DESCRIPTION OF ACCIDENT LOCATION ____________________________________________

IS THIS LOCATION IN A ☐ STATE-OWNED OR ☐ LEASED BUILDING


________________________________________________________________________________________

17. CHECK THE APPROPRIATE ENVIRONMENTAL CONDITION THAT IS APPLICABLE TO THE ACCIDENT: ☐ RAINING ☐ SUNNY ☐ CLOUDY ☐ FOGGY ☐ COLD ☐ HOT ☐ LIGHTNING ☐ WIND

☐ OTHER WEATHER CONDITION _____________________________ ☐ WEATHER NOT A FACTOR

18. CHECK THE APPROPRIATE BOX (S) THAT PERTAINS TO THE ACCIDENT: ☐ LIQUID ON FLOOR—TYPE OF LIQUID ___________________________

☐ STAIRS ☐ PARKING LOT ☐ GARAGE ☐ SIDEWALK ☐ ELEVATORS ☐ GRATING

☐ SPONSORED ACTIVITY ☐ DORMITORY ☐ WAITING ROOM ☐ WALKWAYS ☐ RAILINGS ☐ FURNITURE

☐ FLOORING—DESCRIBE THE TYPE OF FLOOR AND TYPE OF WAX ____________________________

☐ OTHER EQUIPMENT (SPECIFY TYPE) ___________________________________________________

19. IF THE ACCIDENT INVOLVED ITEMS THAT CAN BE RETAINED (i.e. furniture, sunlifter, exam table), THE CLAIMS UNIT Requires That THE ITEM BE TAGGED WITH THE DATE OF ACCIDENT AND NAME OF CLAINTANT. IF THE ITEM IS BROKEN OR DAMAGED, IT MUST BE PLACED IN A SECURED AREA AFTER BEING TAGGED. THE TAG CANNOT BE REMOVED OR THE BROKE/DAMAGE ITEM CANNOT BE SURPLUS/DISCARDED UNTIL NOTIFIED BY THE CLAIMS UNIT. IF APPLICABLE, WAS THIS DONE ___Y__N

20. WAS THE CLAINTANT AUTHORIZED TO BE IN THIS AREA ___Y__N

21. DID ANY EMPLOYEE OBSERVE ANYTHING BEFORE/AFTER THAT IS RELEVANT TO THE ACCIDENT ___Y__N IF YES, WAS A STATEMENT OBTAINED AND ATTACHED ___Y__N

22. DID THE SUPERVISOR OR AGENCY SAFETY OFFICER RECEIVE A REPORT OF ANY OBSERVED CONDITIONS? ___Y__N

23. WERE PICTURES TAKEN AND ARE THEY ATTACHED TO REPORT? ___Y__N

24. NAME AND POSITION OF EMPLOYEE FILLING OUT THIS REPORT ________________________________

________________________________________________________________________________________

PLEASE DATE

KEEP COMPLETED FORMS ON FILE AT THE LOCATION WHERE INCIDENT/ACCIDENT OCCURRED

FORM DA 3000 Revised 07/2011

This form is prepared for internal use only and is prepared in anticipation of litigation.
# ACCIDENT REPORT
LOUISIANA STATE DRIVER SAFETY PROGRAM

Submit report to ORM within 48 hours of accident.

1. Agency Name
2. Person to Contact
3. Phone
4. Loc. Code

5. State Vehicle Driver's Name
6. Personel Number
7. Date of Accident
8. Time of Accident
   - AM
   - PM

9. Exact Location of Accident (Use street markers, mileage markers, etc., to pinpoint location)

10. DESCRIBE HOW ACCIDENT HAPPENED

11. Seat Belt in use
   - Yes
   - No

## STATE VEHICLE INFORMATION
If other then vehicle damage, fill in as much as possible. Under "Other Vehicle" section substituting property owner information for vehicle driver.

13. State Vehicle Driver's Address (Street No.)
14. City
15. State
16. Zip Code
17. Home Phone
18. Work Phone

19. Driver's License No.
20. Age
21. Sex
22. Vehicular Owner's Name and Address

23. Year Vehicle
24. Make Vehicle
25. Model Vehicle
26. Body Type
27. Vehicle Lic. No. / Equip No. / VIN

28. Where can the Vehicle be Seen?
29. Describe Damage

## OTHER VEHICLE INFORMATION
If more than one vehicle is involved, submit additional sheet with information on other vehicle(s).

30. Other Vehicle Driver's Name
31. Other Vehicle Driver's Address (Street No.)
32. City
33. State
34. Zip Code

35. Other Vehicle Driver's License No.
36. Other Vehicle Driver's Age
37. Other Vehicle Driver's Sex

39. Where can the vehicle be seen?
40. Describe Damage
41. Estimated Amount

## INJURED
42. Name and Address
43. Phone
44. PED
45. Other Veh

46. Investigated
47. Type Report
   - Yes
   - No

## WITNESSES OR PASSENGERS
48. Name and Address
49. Phone
50. Witness Passenger
51. Witness Passenger
52. Phone
53. Other Veh

54. State Drivers Signature
55. Name of Driver's Immediate Supervisor and Phone No.
1. Introduction
- OSHA requires employers to establish a written program for preventing the spread of Bloodborne disease
- UL Lafayette has a written plan to keep employees informed:
  [https://safety.louisiana.edu/sites/safety/files/Sec12%20BBP%20and%20other%20communicable%20illnesses%209th%20ed_1.pdf](https://safety.louisiana.edu/sites/safety/files/Sec12%20BBP%20and%20other%20communicable%20illnesses%209th%20ed_1.pdf)
- If an employee comes across blood, they do not have to clean it up. They are to immediately notify their supervisor or the Safety Office (2-1840) or Facility Mgmt (2-6440) for instructions.

2. Bloodborne Disease
- Microorganisms that are present in the human blood that can cause disease.
- Examples include: HIV, HBV, HCV

3. Infectious Material
- BLOOD or fluids from the body (urine, feces, vomit, semen, vaginal fluids)

4. Universal Precautions
- Always wear safety glasses and latex or non-latex plastic gloves
- Goggles, face shields and other PPE are to be made available
- Gloves must be removed carefully in proper sequence (outside of the glove away from skin)

5. Safe Work Practices
- Restroom cleaning and maintenance are not considered occupational exposure
- Sheathed Sharps may be discarded as normal
- Un-sheathed Sharps must be discarded by the user (off campus).
- Discarded feminine hygiene products are not considered regulated waste as long as they are in lined containers. Blood outside of a lined container is a potential exposure.
- Do NOT handle trash from inside a can with bare or gloved hands
- Always wash your hands after taking off gloves

6. Routine cleanup
- Small drops of blood or body fluid can be cleaned up without “occupational exposure”
- If an employee comes into contact with someone else’s blood, they must advise their supervisor immediately for appropriate action
- If an employee cleans up small amounts of blood, it is considered voluntary. Blood cleanup is not a condition of employment.
- For major blood or fluid loss, or whenever a volunteer does not clean up the loss, a qualified contractor will be used.

7. Cleaning a spill
- Cleanup fluids before applying the disinfectant (bleach or another approved disinfectant)
- Properly dispose of contaminated clothing or debris at spill in lined container/bag.
- Leave the surface wet with the disinfectant for at least 10 minutes
- Thoroughly wash hands, arms, and other exposed body part with soap and water
What is Meningococcal disease?
A disease caused by the systemic invasion of the bacteria *Neisseria meningitides*, also known as meningococcus and may be manifested as meningitis (inflammation of the lining of the brain and spinal cord), pneumonia, meningococcemia (febrile bacteremia), and conjunctivitis. Complications may include arthritis, myocarditis, pericarditis and endophthalmitis.

What is meningitis?
Meningitis is an inflammation of the linings of the brain & spinal cord caused by either viruses or bacteria:
- **Viral meningitis** is more common than bacterial meningitis and usually occurs in late spring & early summer. Signs & symptoms of viral meningitis may include stiff neck, headache, nausea, vomiting, and rash. Most cases of viral meningitis run a short, uneventful course. Since the causative agent is a virus, antibiotics are not effective. Persons who have had contact with a person with viral meningitis do not require any treatment.
- **Bacterial meningitis** occurs rarely and sporadically throughout the year, although outbreaks tend to occur in late winter and early spring. Bacterial meningitis in college-aged students is most likely caused by *Neisseria meningitides* or *Streptococcus pneumoniae*. Meningococcal meningitis can cause grave illness and rapidly progress to death; early diagnosis and treatment are imperative. In contrast to viral meningitis, a person who has had intimate contact with a case requires prophylactic therapy. Untreated meningococcal disease can be fatal.

How does meningococcal disease occur?
- Approximately 10% of the general population carries meningococcal bacteria in the nose and throat in a harmless state. This carrier state may last for days or months before spontaneously disappearing, and it seems to give persons who harbor the bacteria in their upper respiratory tracts some protection from developing meningococcal disease.
- During meningococcal disease outbreaks, the percentage of people carrying the bacteria may approach 95%, yet the percentage of people who develop meningococcal disease is less than 1%. This low occurrence of disease following exposure suggests that a person’s own immune system, in addition to bacterial factors, plays a key role in disease development.
- Meningococcal bacteria cannot usually live for more than a few minutes outside the body. As a result, they are not easily transmitted in water supplies, swimming pools, or by routine contact with an infected person in a classroom, dining room, bar, restroom, etc.
- Roommates, friends, spouses, and children who have had intimate contact with the oral secretions of a person diagnosed with meningococcal disease are at risk for contracting the disease and should seek medical evaluation and receive prophylactic medication immediately. Examples of such contact includes sharing of oral secretions, such as kissing, sharing drinks, food, utensils, any type of cigarettes, or any object that was in someone else’s mouth, and being exposed to droplet contamination from the nose or throat, such as from sneezing or coughing.
- The incubation period is 1 to 10 days, usually less than 4 days.

How many cases of meningococcal disease occur each year?
The annual incidence of meningococcal disease in the U.S. is about 1 to 2 cases per 100,000 population. The case fatality rate is approximately 12%.
Can meningococcal disease be mistaken for other health problems?
YES. Meningococcal disease is potentially dangerous because it is relatively rare and can be mistaken for other conditions. The possibility of having meningitis may not be considered by someone who feels ill, and early signs and symptoms may be ignored. A person may have symptoms suggestive of a minor cold or flu for a few days before experiencing a rapid progression to severe meningococcal disease.

What are the signs & symptoms of meningococcal disease?
Understanding the characteristic signs and symptoms of meningococcal disease is critical & possibly lifesaving. Common early symptoms of meningococcal disease include fever, leg pain, cold hands and feet, abnormal skin color, severe sudden headache accompanied by mental changes (confusion, fatigue), nausea and vomiting light sensitivity and neck stiffness. A rash may begin as a flat, red eruption, mainly on the arms & legs. It may then evolve into a rash of small dots that do not change with pressure (petechiae). New petechiae can form rapidly, even while the patient is being examined.

What is the treatment for meningococcal disease exposure?
Treatment of infected persons: Meningococcal disease can become rapidly progressive within hours of onset of the symptoms. With early diagnosis and treatment, however, the likelihood of full recovery is increased. Early recognition, performance of a lumbar puncture (spinal tap) and prompt initiation of antimicrobial therapy are crucial.

Chemoprophylaxis: The use of such prophylactic antibiotics as Ciprofloxacin, Rifampin or Rocephin is recommended for those who may have been exposed to a person diagnosed with meningococcal disease, and is considered at risk. These antibiotics kill or eliminate the bacteria in the at risk person’s nose and throat, thereby decreasing the risk of them from passing the disease or becoming ill. Anyone who suspects possible exposure should consult a physician immediately to determine their risk status.

Vaccination: As an adjunct to appropriate antibiotic chemoprophylaxis, immunization against the meningococcus bacterium may be recommended when an outbreak of meningococcal disease has occurred in a community. It is important to note that meningococcal vaccine should not be used in place of chemoprophylaxis for those exposed to an infected person. The protection from immunization begins within 7 to 10 days and is too slowly generated in this situation.

Meningococcal Meningitis Vaccine
Immunization against the bacterium N. meningitides may be recommended if they are members of a population that is experiencing an outbreak of meningococcal disease, e.g., students at a university where an outbreak has occurred.

As with any vaccine, vaccination may not protect 100% of all susceptible individuals. Adverse reactions to meningococcal vaccine are mild & infrequent, consisting primarily of redness & pain at the injection site that may last 1-2 days. Rarely, fever of short duration may occur.

How can one reduce the risk of contracting meningococcal disease?
Maximize your body’s own immune system response. A lifestyle that includes a balanced diet, adequate sleep, appropriate exercise, & the avoidance of excessive stress is very important. Avoiding upper respiratory tract infections & inhalation of cigarette smoke may help to protect from invasive disease. Everyone should be sensitive to public health measures that decrease exposure to oral secretions, such as, covering one’s mouth when coughing or sneezing & washing hands after contact with oral secretions.