NJGSS INFORMATION ON HEALTH SERVICES

TO PARENTS:

Summer health care facilities on the Drew University campus are limited to the regular students, faculty, and staff of the university. Should a physician's care be required, it must be obtained off campus. Drs. Weine, Renna, and Meyers of Madison Internal Medicine Associates, P.A., 95 Madison Ave., Morristown, NJ, (973) 829-9998, have agreed to accept Governor's School Scholars as patients should the need arise. Their offices are approximately two miles from the campus. Billing for such services will be made directly to the parents.

In non-emergency situations, should your child, in her/his judgment or ours, require medical attention, we will attempt to contact you or have your child contact you. If we are able to reach you and you are not too far away and wish to attend to the situation, you may take your child to your own physician. We encourage you to do that. If we are not able to reach you, or if you cannot come to Drew, we will consult the physicians named above or their covering doctors. To this end, please sign the authorization statement.

In emergencies, should they arise, we will do what is necessary, using available local hospitals or physicians, contacting you for authorization when feasible. Please sign the emergency authorization statement. In addition, please provide us with a copy of the FRONT and BACK of your health insurance ID card, if applicable.

The student body of the Governor's School will be covered under a special events insurance policy. However, the student's medical, dental, and hospital expenses are not covered by Drew University or the Governor's School and remain the responsibility of the parents and/or your family health insurance. If your child is not covered by your policy, we suggest you investigate a short-term policy for this purpose.
2015 NJGSS HEALTH CARE AUTHORIZATION FORM

Name of Scholar (Please PRINT)  Date of Birth

I authorize the staff of the New Jersey Governor's School in the Sciences to seek medical attention from Drs. Weine, Renna, and Meyers of Madison Internal Medicine Associates, P.A., or their covering doctors on behalf of the student named above. If they are unable to reach me, I authorize the physicians named to render treatment according to good medical practice.

____________________________________________________________________________

Signature of Parent or Guardian  Date

Name of Parent or Guardian (Please PRINT)  Date

I hereby authorize the staff of the New Jersey Governor's School in the Sciences, in case of emergency, to seek appropriate medical treatment from available hospitals or physicians as necessary, and, when they are unable to reach me for authorization or when circumstances require immediate action, authorize those hospitals or physicians to proceed according to good medical practice in the treatment of the student named above.

____________________________________________________________________________

Signature of Parent or Guardian  Date

Name of Parent or Guardian (Please PRINT)  Date

THIS COMPLETED FORM MUST BE RETURNED, VIA US MAIL, POSTMARKED NO LATER THAN MAY 30, 2015
2015 NJGSS GENERAL HEALTH FORM

Name of Scholar __________________________________ Birth Date_______________ Sex M___ F____
(Please PRINT)

Parent/Guardian: Name __________________________________________________________
Address ________________________________________________________________

Daytime Phone (____)_________ Evening Phone   (____)_____________

Person, other than Parent/Guardian and not in the same household, to contact in an emergency:

Name ______________________________________________________________
Address ______________________________________________________________

Daytime Phone (____)_________ Evening Phone   (____)_____________

Physician: Name __________________________________________________________
Address __________________________________________________________________

Phone   (____)_____________

Is the student currently under doctors’ care? Circle: YES NO
If YES, please list conditions we should know about and medications, dosages, and reasons for medications.
________________________________________________________________________

List any special food or dietary requirements (we will notify Food Services) __________________________________________________________________

List any allergies which may be relevant under emergency conditions (such as penicillin, bee stings, etc.)
________________________________________________________________________

Do you need special accommodations due to an ADA-defined disability? Circle: YES NO
If Yes, explain: __________________________________________________________________

Date of most recent tetanus vaccination _____________________________________________

INSURANCE: Name of Company _____________________________________________________
(If you do NOT have insurance, write “None”. DO NOT LEAVE BLANK!)

Subscriber’s Name ___________________________________ Policy Number ________________________

PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD.

In your opinion, is the student in good overall health? Circle: YES NO

Signature of Parent or Guardian __________________________________ Date ________________

THIS COMPLETED FORM MUST BE RETURNED, VIA US MAIL, POSTMARKED NO LATER THAN MAY 30, 2015