TO PARENTS:

During the Summer College, health care will not be available for visiting students on the Drew campus. In order to take the best care of students while they are on campus, we have made arrangements to ensure the availability of good health care should the students need it.

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 take your child to a walk-in Omnimed clinic about 10-minutes from campus. Please sign the attached health information and authorization forms, so that we have the authority to seek treatment for your child and the essential information we need to do so.

In emergencies, should they arise, we will do what is necessary, using available local hospital, most often the Morristown Memorial Hospital, and contacting you for authorization when feasible.

The student body of the Summer College will be covered under a blanket liability insurance policy subscribed to by Drew University. However, the student's medical, dental, and hospital expenses are not covered by Drew University or the Summer College and remain the responsibility of the parents and/or your family health insurance.
SUMMER COLLEGE HEALTH CARE AUTHORIZATION FORM
Drew University

_____________________________  ___________________
Student's Name (Please PRINT)  Date of Birth

I hereby authorize the staff of the Drew University Summer college Program, 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.

_____________________________
Name of Parent/Guardian (please print)

_____________________________
Signature of Parent/Guardian

_____________________________
Date
DREW SUMMER COLLEGE GENERAL HEALTH FORM

Student’s Name: ___________________________ Birth Date: ______________________
(Please PRINT Clearly)

Sex (Circle): M   F

Parent/Guardian: Name ________________________________________________
                 Address ________________________________________________

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

E-mail _________

Person other than Parent/Guardian 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 Service)
________________________________________________________________________
________________________________________________________________________
List any allergies which may be relevant under emergency conditions (such as penicillin, bee stings, etc.)
________________________________________________________________________
________________________________________________________________________
Does the student need special accommodations due to an ADA-defined disability (Circle)?
YES    NO
If Yes, explain:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Date of most recent tetanus vaccination ____________________________

HEALTH INSURANCE INFORMATION

Insurance: Name of Company
________________________________________________________________________
If you have no insurance, write "none". Do not leave blank!

Subscriber's Name ____________________________

Policy Numbers ____________________________

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/Guardian
________________________________________________________________________

Print Name ____________________________

Date ____________________________