



The Governor's School of New Jersey at Drew University
The School of the Sciences
Madison, New Jersey 07940-4037



GSNJS 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. 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.

2024 GSNJS 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 UPLOADED, VIA GOOGLE FORM,
BY MAY 24, 2024**

2024 GSNJS 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 UPLOADED, VIA GOOGLE FORM,
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