

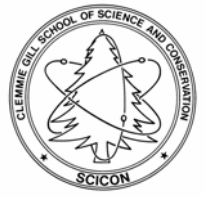
Attendance Dates:

From: _____

To: _____

SCICON

Clemmie Gill School of Outdoor Science and Conservation
Tulare County Office of Education



COUNSELOR HEALTH REGISTRATION

Name of Student	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth
School	School Phone	Teacher	
Home Address (Street)	(City)	(Zip Code)	Home Phone ()
Father/Guardian Name	Work Phone ()	Cell Phone/Pager ()	
Mother/Guardian Name	Work Phone ()	Cell Phone/Pager ()	
Name of Family Physician		Physician's Phone ()	

PERSONS TO CONTACT IN AN EMERGENCY IF PARENTS CANNOT BE REACHED

Name	Relationship to Student	Home Phone ()	Work Phone ()	Cell Phone ()
Name	Relationship to Student	Home Phone ()	Work Phone ()	Cell Phone ()

COUNSELOR HEALTH INFORMATION

1. Does your child have a **recent** history of any of the following conditions? Please check all that apply.

A. <input type="checkbox"/> ADD or ADHD <input type="checkbox"/> Sending RX	D. <input type="checkbox"/> Bedwetting	N. <input type="checkbox"/> Recent broken bone or surgery
B. Allergies	E. <input type="checkbox"/> Bowel problems	O. <input type="checkbox"/> Recently ill
<input type="checkbox"/> Bee sting/insect bites (circle)	F. <input type="checkbox"/> Diabetic	P. <input type="checkbox"/> Restriction of strenuous activity (hiking, games, etc.)
<input type="checkbox"/> Food _____	G. <input type="checkbox"/> Epilepsy or seizure disorder	Q. <input type="checkbox"/> Sleep walking
<input type="checkbox"/> Hay fever	H. <input type="checkbox"/> Fainting	R. <input type="checkbox"/> Special Diet
<input type="checkbox"/> Medication _____	I. <input type="checkbox"/> Headache	S. <input type="checkbox"/> Stomach problems
<input type="checkbox"/> Other _____	J. <input type="checkbox"/> Heart condition	T. <input type="checkbox"/> Other
Child's reaction _____	K. <input type="checkbox"/> Homesickness	
*Treatment needed _____	L. <input type="checkbox"/> Nosebleed	
C. <input type="checkbox"/> Asthma <input type="checkbox"/> Sending RX	M. <input type="checkbox"/> Over weight	

*If your child requires a shot of Epinephrine due to an allergic reaction, the medication should be sent with the child and labeled by the pharmacy with full instructions.

Briefly explain **ALL** items checked above (refer to each item by letter) and explain any other medical issues not listed above (use additional sheets if necessary). **Please also disclose any medically necessary dietary requirements.**

2. Yes No Does your child have a physical or emotional special need or condition? If yes, please explain below. A student with a special needs is defined as one who may, due to physical or emotional condition, require individualized care or medical attention. Examples include, but are not limited to: diabetes, mobility challenged students, students who regularly use a nebulizer, emotionally challenged students, and students who need help with ADL's (Activities of Daily Living).

My child requires an aide at school.

3. Approximate date of last known tetanus/toxoid shot.

4. If your child is under a doctor's care for an acute or chronic problem, your physician needs to know that the child will be away from home for four or five full days. Is a specialized medical request form on file at your child's school? Yes No
If no, and "special medical care" is needed, physicians instructions are required. Please have your doctor complete Section II on the opposite side.

5. MEDICAL INSURANCE
Medi-Cal? _____ # _____ Healthy Families Card? _____ # _____
Private Insurance? _____ Co. Name _____ Policy # _____

THE STATEMENTS BELOW MUST BE SIGNED BEFORE YOUR CHILD CAN BE ACCEPTED AT SCICON

Authorization for medical treatment: For my child _____

I hereby authorize emergency medical or surgical care at the nearest hospital, should a medical emergency arise and I am not immediately available.

PARENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

PLEASE COMPLETE OTHER SIDE

MEDICATION REQUEST FORM
NO MEDICATION IS GIVEN WITHOUT PARENT AND/OR PHYSICIAN PERMISSION

SECTION I TO BE COMPLETED BY PARENT OR GUARDIAN

Nonprescription Medications (at SCICON)

Occasionally, it is necessary to provide students with nonprescription medications when they are at SCICON. The medications listed below are kept in stock at SCICON for this purpose. **Please do not send any of these to SCICON.** Please check the yes or no box below to **indicate your permission** for the listed medication (some may be generic) to be administered by the SCICON nurse, or an authorized SCICON staff member.

(PLEASE CHECK)

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Advil (minor pain/menstrual pain)	<input type="checkbox"/>	<input type="checkbox"/>	Imodium (diarrhea)
<input type="checkbox"/>	<input type="checkbox"/>	Benadryl (allergic reactions)	<input type="checkbox"/>	<input type="checkbox"/>	Milk of Magnesia (constipation)
<input type="checkbox"/>	<input type="checkbox"/>	Calamine lotion (insect bites)	<input type="checkbox"/>	<input type="checkbox"/>	Polysporin Topical (minor cuts/burns)
<input type="checkbox"/>	<input type="checkbox"/>	Tums (upset stomach)	<input type="checkbox"/>	<input type="checkbox"/>	Robitussin (cough)
<input type="checkbox"/>	<input type="checkbox"/>	Hydrocortisone Cream (itch/rash)	<input type="checkbox"/>	<input type="checkbox"/>	Tylenol (minor pain/fever)

NAME OF PUPIL

I request that my child (named above) be assisted by authorized persons in taking the described medications listed in Section I and Section II (as applicable) at SCICON in compliance with established policies and procedures.

DATE SIGNED (MO/DAY/YEAR)

HOME PHONE
()

SIGNATURE OF PARENT OR GUARDIAN
X

Important: Is your child bringing prescription or nonprescription medication to SCICON? Yes _____ No _____.
If "Yes", then you must complete Section II of this form. We cannot administer any medication (including prescription, nonprescription, vitamins, or herbal remedies) you send for your child without completion of Section II.

SECTION II TO BE COMPLETED BY CHILD'S PHYSICIAN

Prescription and Nonprescription Medications (from home)

If your child regularly takes prescribed medication, and/or nonprescription medication, other than those listed above, and if you want your child to receive medication at SCICON, it is necessary that the medication request form be completed and signed by you and your physician. Additional medication request forms may be obtained by contacting your child's teacher.

The SCICON nurse will keep all prescription and nonprescription medications locked in the Health Center and will dispense them as prescribed. **Prescription and/or nonprescription medications can not be given unless they are in their original container. Medications must be labeled with student's name, teacher, school, and precise dosage instructions.** Only asthma inhalers may be kept in the student's cabin. Do not pack medications, (including inhalers), in child's luggage. The teacher will collect it before the trip.

MEDICATION(S)

	NAME OF MEDICATION A.	NAME OF MEDICATION B.	NAME OF MEDICATION C.	NAME OF MEDICATION D.
PURPOSE OF MEDICATION				
DOSAGE PRESCRIBED				
TIME SCHEDULE				
DOSE FORM (tablet, liquid, etc.)				
PRESCRIPTION DATE	Date Prescribed Date Expires	Date Prescribed Date Expires	Date Prescribed Date Expires	Date Prescribed Date Expires
LENGTH OF TIME MEDICATION IS NECESSARY				

PRECAUTIONS, SPECIAL INSTRUCTIONS, POSSIBLE ADVERSE EFFECT(S), OR COMMENTS:

PRINT NAME OF PHYSICIAN

TELEPHONE NUMBER

NAME OF MEDICAL OFFICE

ADDRESS (Number, Street name, Suite or Room number, City, State, and Zip Code)

The above named pupil for whom the medication in Section I and II are prescribed is under my care.

SIGNATURE OF PHYSICIAN

DATE SIGNED