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 ☐ Female ☐	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. ☐ ADD or ☐ ADHD ☐ Sending RX
B. Allergies
☐ Bee sting/insect bites (circle)
☐ Food _____
☐ Hay fever
☐ Medication _____
☐ Other _____
Child's reaction _____
*Treatment needed _____
C. ☐ Asthma ☐ Sending RX
D. ☐ Bedwetting
E. ☐ Bowel problems
F. ☐ Diabetic
G. ☐ Epilepsy or seizure disorder
H. ☐ Fainting
I. ☐ Headache
J. ☐ Heart condition
K. ☐ Homesickness
L. ☐ Nosebleed
M. ☐ Recent broken bone or surgery
N. ☐ Recently ill
O. ☐ Restriction of strenuous activity (hiking, games, etc.)
P. ☐ Sleep walking
Q ☐ Special Diet
R. ☐ Stomach problems
S. ☐ Other

*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	
☐	☐	Advil (minor pain/menstrual pain)	☐	☐	Claritin (hayfever)
☐	☐	Benadryl (allergic reactions)	☐	☐	Imodium (diarrhea)
☐	☐	Calamine lotion (insect bites)	☐	☐	Polysporin Topical (minor cuts/burns)
☐	☐	Tums (upset stomach)	☐	☐	Robitussin (cough)
☐	☐	Hydrocortisone Cream (itch/rash)	☐	☐	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