Attendance Dates: _____

SCICON

Tulare County Office of Education

****If your child is bringing *any* medications with them, a medical provider MUST complete Section II (back side) of this form; otherwise, the medications *will not* be administered per CA State Law****

COUNSELOR HEALTH REGISTRATION

Student Name		Male ☐ Female ☐	**Date of Birth**
School	**Teacher**		
Home Address (Street)	(City)	(Zip Code)	Home Phone ( )
Mother/Guardian Name	Work Phone ( )		Cell Phone ( )
Father/Guardian Name	Work Phone ( )		Cell Phone ( )
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 ( )

STUDENT HEALTH INFORMATION

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

A. ☐ ADD or ☐ ADHD
B. Allergies to (if checked, describe below)
☐ Bee sting ☐ Food
☐ Insect ☐ Medication
☐ Other
Allergen _____
Reaction & Treatment needed - _____
_____
_____

C. ☐ Asthma
D. ☐ Bedwetting
E. ☐ Bowel problems
F. ☐ Diabetes
G. ☐ Epilepsy or seizure disorder
H. ☐ Fainting
I. ☐ Headache
J. ☐ Heart condition
K. ☐ Separation anxiety

L. ☐ Frequent nosebleeds
M. ☐ Recent broken bone/surgery
N. ☐ Recently ill
O. ☐ Restriction of strenuous activity
P. ☐ Sleep walking
Q ☐ Special dietary request
R. ☐ Stomach problems
S. ☐ Mental Health Concerns
T. ☐ Other

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 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 special camping needs could be related to physical, mental, emotional, or social conditions requiring *individualized* supportive attention and care. Examples include, but are not limited to: mobility challenges, emotional dysregulations, diagnosed mental illness, and/or students who need help with ADL's (Activities of Daily Living).

_____
_____
_____
_____

☐ **My child requires an aide at school.**

3. 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 and nights. **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.

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

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

Authorization for medical treatment: For my child _____
(STUDENT NAME)

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

PARENT/ LEGAL GUARDIAN SIGNATURE_____ DATE_____

PLEASE COMPLETE OTHER SIDE OF FORM

MEDICATION REQUEST FORM

SECTION I - TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

- SCICON partners with a local physician to be able to administer a select few over-the-counter medications for campers with minor illnesses and injuries with parental permission for the duration of camp. They are listed below with dosages and reasons for administration. They are only administered *as needed* and with student cooperation.
- If you do *not* wish for the SCICON Nurse to administer these medications if needed, please check mark which medications you do not give permission for, then sign the box directly below.
- If you wish to give permission, please simply sign the box directly below and leave the medication boxes *unchecked*.

NO PERMISSION	NO PERMISSION	NO PERMISSION
☐ Advil 400mg - minor pain/menstrual pain	☐ Tylenol 650mg - minor pain/fever	☐ Cough drops – sore throat, cough
☐ Benadryl 25mg - allergic reactions	☐Polysporin Topical- minor cuts/burns	☐ Saline – minor eye irritation
☐ Calamine lotion- insect bites	☐ Hydrocortisone Cream- itch/rash	☐ Melatonin 5mg – difficulty sleeping
☐ Claritin 10mg - seasonal allergies	☐ Antacid - upset stomach	☐ Aloe Vera - burns

NAME OF STUDENT

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	PARENT/LEGAL GUARDIAN NAME	SIGNATURE OF PARENT OR LEGAL GUARDIAN

NO MEDICATIONS OR SUPPLEMENTS WILL BE GIVEN WITHOUT PHYSICIAN APPROVAL IN SECTION II

SECTION II- Prescription and Nonprescription Medications (from home)

- **ALL** medications/therapies/supplements (including over-the-counter) MUST have an order signed by a physician, per California State Law.
- All medications must be in original, labeled prescription bottle. *NO pill organizers will be accepted.*
- Additional medical forms may be obtained from your teacher/school nurse if you need additional space.
- All medications will be kept by the SCICON Nurse and dispensed as prescribed.
- Standard medication distribution times are *approximately* Breakfast (0730), Lunch (1215), Dinner (1730), Bedtime (2000)
- **Medications must be clearly labeled with the student's name, teacher, school, and precise dosage instructions.**
- **Do not** pack medications (including inhalers) in your child's luggage. The teacher or nurse will collect it before the trip
- Student will be expected to self- carry any necessary emergency medications (inhalers, epinephrine, glucagon, etc..) *after* the SCICON Nurse checks them in and provides education on self-carry while at SCICON.

SECTION II - TO BE COMPLETED BY CAMPER'S PHYSICIAN

Prescribers: Please do not put "QD" or "BID" for the time. Please specify specific meal times to administer medications "Breakfast", "Lunch", "Dinner", "Bedtime", etc. DOSAGE should include mg/mL, not just "1 tab".

MEDICATION NAME				
PURPOSE OF MEDICATION (ADHD, allergies, asthma, etc.)				
DOSAGE PRESCRIBED (specific to mg/mL, not # pills)				
TIME SCHEDULE (breakfast, lunch, dinner, bedtime, or specific time)				
DOSE ROUTE (oral, inhaled, nasal, etc..)				

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**