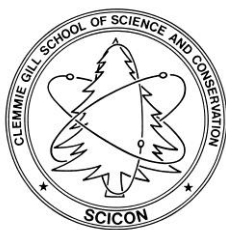

SCICON

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

TEACHER REGISTRATION FORM

Week Attending____________________________ School __________________________________

Date of Birth ___________________________________

Name _________________________________ School Telephone ______________________________

Home Address_________________________ Home Telephone ______________________________

City______________________ Zip___________ Cell Phone_____________________________________

Person to contact in case of emergency:

(1) Name__________________________________ Home Telephone___________________________

Address_______________________________ Business Telephone_________________________

Cell Phone Number ________________________

(2) Name__________________________________ Home Telephone___________________________

Address_______________________________ Business Telephone_________________________

Cell Phone Number ______________________

Are you taking a daily medication?_____ If yes, what medicine? ________________________________

For what condition?____

Do you take other medications at times?_____ If yes, what? ___________________________________

For what condition?_____________________________________

Do you have a health problem that could restrict your activities at SCICON

(Such as hypertension, arthritis, asthma)? _______ If yes, please specify.________________________

____

Do you have an allergy to a medicine (penicillin, for example), food or insect bites or

stings? _______ If yes, what,____

What treatment is required?____

Have you had any recent illness, surgery, broken bones, etc.?_________________________________

If yes, please specify.____

Do you have any religious restrictions regarding medical aid?___________________________________

If yes, please specify.____

Do you have medical insurance? _____ Name of company______________________________________

Policy #____

Physician's Name ____

Address__________________________________ City_________________________ Zip_____________

Telephone Number ____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT:

I hereby authorize the Clemmie Gill School of Science and Conservation (SCICON) to provide medical or surgical care rendered through the facilities of the nearest hospital or doctor's office in any emergency which may occur while I am at SCICON.

_________________________ ____

Date Signature