

SCICON

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



TEACHER REGISTRATION FORM

Week Attending _____

School _____

Name _____ School Telephone _____

Home Address _____ Home Telephone _____

City _____ Zip _____ Date of Birth _____

Person to contact in case of emergency:

(1) Name _____ Home Telephone _____

Address _____ Business Telephone _____

(2) Name _____ Home Telephone _____

Address _____ Business Telephone _____

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