Thank you for applying to Nursing Camp in Summer at UC Irvine.

The Nursing Camp in Summer at UC Irvine is a one-week summer program that introduces the nursing career discipline to high school students. NCIS: UCI offers an engaging curriculum based on classroom and boot camp simulation workshops that will provide hands-on experience to nursing skills. Students will also work on writing a college personal statement and creating a health education research project. At the conclusion of the week, students will have the opportunity to present their research projects at the camp reception for family and friends.

To learn more about NCIS: UCI, please visit http://sites.uci.edu/ncis/

ELIGIBILITY:
- High school students entering their junior or senior year in the fall of 2019
- Over the age of 15

CAMP APPLICATION CHECKLIST:
- [ ] Camp Application
- [ ] Waiver of Liability
- [ ] Consent to Photograph/Video
- [ ] Program fee payment: http://sites.uci.edu/ncis/fee/
- [ ] FOR SCHOLARSHIP APPLICANTS, PLEASE ALSO INCLUDE:
  - [ ] Scholarship Application
  - [ ] Student's High School Transcript (official or unofficial)
  - [ ] Letter of Recommendation (by teacher or counselor)

DEADLINE: May 1, 2019

MAIL/EMAIL YOUR COMPLETED CAMP APPLICATION ALONG WITH THE PROGRAM FEE TO:

NCIS: UCI
Sue & Bill Gross School of Nursing
University of California, Irvine
290 Berk Hall
Irvine, CA 92697-3959

ncisuci@hs.uci.edu

Questions?
Contact us:
Phone: (949) 824-3630
Email: ncisuci@hs.uci.edu
CAMP APPLICATION

Last Name: ____________________________ First Name: ____________________________

Birthdate: ____________________________ School: ____________________________ Fall 2019 Grade: ________

Phone: ____________________________ Email: ____________________________

Parent/Guardian Name: ____________________________

Street Address: ____________________________

City, State, ZIP: ____________________________

Phone: ____________________________ T-Shirt Size: □ S □ M □ L □ XL

Camp Session Preference: □ Session 1 is now full. □ Session 2: August 5 – 9, 2019

Emergency Contact (other than parent or guardian)

Name: ____________________________

Phone: ____________________________ Relationship: ____________________________

Which of the phrases below best describes your racial/ethnic background? (optional)

□ African American/Black □ Asian-American, Pacific Islander □ Hispanic or Latino/a origin
□ American Indian/Alaskan Native □ Caucasian/White □ I prefer not to respond

How did you hear about NCIS: UCI? (check all that apply and please specify)

□ Friend/Relative □ Poster/flyer □ UCI Faculty/Staff: ____________________________
□ Teacher/Counselor □ Internet □ Other: ____________________________

Please make all checks payable to “UC Regents”

OFFICE USE ONLY – PAYMENT INFORMATION

Amount enclosed: ____________________________ Date: ____________________________

□ Check/Money Order/Cashier’s Check (Payable to UC Regents): ____________________________
STUDENT HEALTH FORM

Last Name: ___________________________ First Name: ___________________________

Insurance Information

Is the student covered by family medical/hospital insurance? □ Yes □ No
If yes, indicate Insurance Carrier: ____________________________________________
Group #: ____________________________ Policy #: ____________________________
Policy Holder’s Name: ____________________________ Relationship to student: ____________

Medications

Will the student be taking medications while at NCIS: UCI? □ Yes □ No
NCIS: UCI Staff is not responsible for administering prescribed medication. Please include student’s medical conditions and/or special needs by listing all (prescription and non-prescription). Use an additional sheet if needed.
Medication____________________________  Dosage_______________________ Take at what times__________________
Prescribing Physician___________________________ Phone____________________________

Allergies

Does the student have any allergies? (Please check all that apply).

□ Hay fever
□ Poison Ivy/Oak
□ Insect Stings
□ Food: ____________________________
□ Penicillin
□ Other: ____________________________
List the allergy and describe the reaction and treatment.
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
□ Student has NO allergies.

Health History

Does the student have a history or is prone to any of the following? (Please check all that apply).

□ Recent injury or illness
□ Infectious disease
□ Chronic or recurring illness
□ Frequent ear infections
□ Seizure Disorder or convulsions
□ Dizziness during/after exercise
□ Chest pain during/after exercise
□ Bleeding/Clotting Disorders
□ Frequent stomachaches
□ Frequent headaches
□ Heart defect/disease
□ Been hospitalized
□ Hypertension
□ Diabetes
□ Chicken pox
□ Measles
□ Tuberculosis
□ Joint problems
□ Head injury
□ Eating disorder
□ Asthma
□ Homesickness
□ Other: ____________________________

TO PARTICIPANT, PARENT, OR GUARDIAN

Is there anything else about the participant that we should know about? □ Yes □ No  If “Yes,” explain.
_________________________________________________________________________
_________________________________________________________________________
TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE  (to be completed by the student)

Last Name: ___________________________   First Name: ___________________________

History Questions (ALL QUESTIONS MUST BE ANSWERED)  

<table>
<thead>
<tr>
<th>Questions</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had a positive TB skin test in the past?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever had close contact with anyone known or suspected to have active TB disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were you born in one of the countries listed HERE that have a high incidence of active TB disease? (If yes, please specify the country: ___________________________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had frequent or prolonged visits to one or more of the countries listed HERE with a high prevalence of TB disease? (If yes, please specify the country: ___________________________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease, medically underserved, low-income, or abusing drugs or alcohol?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been told by a health care provider that your immune system is not working right or cannot fight infection? (e.g. immune disorder or illness such as HIV infection)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the answer to ALL of the above questions is “NO”, Tuberculosis (TB) Testing is not required.

If the answer is “YES” to any of the above questions, UC Irvine requires that you receive TB testing as soon as possible.

Please have your health care provider complete the “Tuberculosis (TB) Testing” below.

TUBERCULOSIS (TB) TESTING  (to be completed by a licensed medical professional)

Please have a licensed medical professional complete this section if you answered “YES” to any of the questions on the “Tuberculosis Screening Questionnaire.” If you answered “NO” to all of the questions you may skip this section.

Tuberculin Skin Test (TST):
Date Given: ___________ Date Read: ___________ Result: _______________ mm (Check one):  
☐ Negative  ☐ Positive

OR

Interferon Gamma Release Assay (IGRA) *Recommended if the student had prior history of BCG:

Specify Method:  
☐ QFT-G  ☐ QFT-GIT  ☐ T-Spot  ☐ Other:

Date of Test:  
Result:  
☐ Negative  ☐ Positive  ☐ Indeterminate  ☐ Borderline (T-Spot only)

Chest X-Ray (Required if TST or IGRA is POSITIVE)
Date of Chest X-Ray: ___________ Result: ___________

History of INH (Isoniazid) Treatment and or other TB drug treatment?  
☐ Yes  ☐ No

If Yes, Date Initiated: ___________ Date Completed: ___________  ☐ Treatment ongoing

Medical Professional completes:

Name: ___________________________________  Professional Title: ___________________________________  License No.: __________________________
Address: ___________________________________  City: ___________  State: ___________  Zip: ___________
Phone: _______________________________  FAX: _______________________________  Email: _______________________________ @ __________________________
Signature: ___________________________________ Date: __________________________
CAMP APPLICATION – PLEASE READ AND COMPLETE

IMPORTANT:
PARTICIPATION IN THE Nursing Camp in Summer at UC Irvine PROGRAM DEMANDS
A COMMITMENT OF ATTENDANCE ON JULY 15 - 19, 2019 (SESSION 1) OR AUGUST 5 - 9, 2019
(SESSION 2) FROM 8:30AM-4:30PM.

NCIS: UCI IS A DAY CAMP AND DOES NOT OFFER OVERNIGHT ACCOMMODATIONS.
TRANSPORTATION IS YOUR RESPONSIBILITY.

THE UNIVERSITY OF CALIFORNIA, IRVINE SUE & BILL GROSS SCHOOL OF NURSING AND NCIS: UCI
RESERVES THE RIGHT TO REMOVE STUDENTS FROM THE SUMMER PROGRAM AT ANY TIME FOR
MISCONDUCT OR NON-COMPLIANCE WITH POLICIES AND PROCEDURES.

I CERTIFY THAT I FULLY UNDERSTAND THE ABOVE GUIDELINES AND THAT THE INFORMATION GIVEN IN
THIS APPLICATION IS TRUE AND CORRECT.

Signature of Applicant: ___________________________ Date: ____________

Signature of Parent/Guardian: ___________________________ Date: ____________

The University of California, Irvine is an Equal Opportunity/Affirmative Action Employer advancing inclusive excellence. All qualified
applicants will receive consideration without regard to race, color, religion, sex, sexual orientation, gender identity, national origin,
disability, age, protected veteran status, or other protected categories covered by the UC nondiscrimination policy.

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