HILLSBOROUGH COUNTY SHERIFF'S OFFICE
RISING STARS LEADERSHIP ACADEMY

EMERGENCY NOTIFICATION INFORMATION, MEDICAL CONDITIONS DISCLOSURE, AND AUTHORIZATION FOR MEDICAL TREATMENT

Date:_____

Name of Student/Child:_____ Date of Birth:_____

School Name:_____

Home Address:_____

Home Telephone: _____ Cell Phone:_____

I. Emergency Notification Information

(A) Mother/Legal Guardian

Name:_____

Home Address:_____

Employer Name and Address:_____

Home Telephone:_____ Cell Phone:_____

Work Telephone:_____ Email:_____

(B) Father/Legal Guardian

Name:_____

Home Address:_____

Employer Name and Address:_____

Home Telephone:_____ Cell Phone:_____

Work Telephone:_____ Email:_____

II. Medical Conditions Disclosure

(A) Is the Student/Child subject to any of the following conditions (past or present)?

Medical Condition	Past		Present	
Allergies	Yes ☐	No ☐	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Yes ☐	No ☐
Back Injuries	Yes ☐	No ☐	Yes ☐	No ☐
Broken Bones	Yes ☐	No ☐	Yes ☐	No ☐
Chest Pain/Palpitations	Yes ☐	No ☐	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Yes ☐	No ☐
Drug Reactions	Yes ☐	No ☐	Yes ☐	No ☐
Epilepsy/Seizures	Yes ☐	No ☐	Yes ☐	No ☐
Headaches	Yes ☐	No ☐	Yes ☐	No ☐
Hearing Problems	Yes ☐	No ☐	Yes ☐	No ☐
Heart Attack	Yes ☐	No ☐	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Yes ☐	No ☐
Knee Injuries	Yes ☐	No ☐	Yes ☐	No ☐
Neck Injuries	Yes ☐	No ☐	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	Yes ☐	No ☐
Thyroid Disorder	Yes ☐	No ☐	Yes ☐	No ☐
Vision Problems	Yes ☐	No ☐	Yes ☐	No ☐

If the answer was "Yes" regarding any of the medical conditions listed above, please describe in detail:_____
_____
_____

(B) Does the Student/Child have any medical conditions which were not listed above (past or present)?
Yes ☐ No ☐

If "Yes," please describe in detail:_____
_____
_____

(C) Does the Student/Child have any food allergies or dietary restrictions?
Yes ☐ No ☐

If "Yes," please describe in detail:_____
_____
_____

(D) Is the Student/Child currently prescribed any medication?
Yes ☐ No ☐

If "Yes," please describe in detail, including: the medical condition, name of the medication, dosage, and frequency:_____
_____
_____

(E) Identify the Student/Child's Primary Care Physician

Name:_____
Address:_____
Telephone: _____

(F) Include a copy of any applicable health insurance card (front and back) with this document.

CERTIFICATION

By signing below, I hereby certify that the medical information provided herein is true and accurate.

_____	_____	_____
Name of Student/Child	Signature of Student/Child	Date
_____	_____	_____
Name of Parent/Legal Guardian	Signature of Parent/Legal Guardian	Date
_____	_____	_____
Name of Parent/Legal Guardian	Signature of Parent/Legal Guardian	Date

* *If the Student/Child is 17 years old or younger, Parent/Legal Guardian signature(s) are required* *

III. Authorization for Medical Treatment

In the event of illness, injury, or medical emergency involving my Student/Child which occurs in connection with their participation in the HCSO Rising Stars Academy, I request that Hillsborough County Sheriff's Office ("HCSO") employees notify, if possible, the person(s) listed above in the Emergency Notification Information.

If the listed person(s) cannot be reached or if my Student/Child requires immediate medical treatment, I authorize HCSO employees, to render medical care/treatment or to seek additional medical care/treatment for my Student/Child. This includes my authorization for HCSO employees to consent on my behalf for my Student/Child to receive medical care/treatment, including but not limited to: transportation by ambulance; diagnostic examinations; administration of medication or anesthesia; and any medical procedures or surgeries deemed necessary or advisable by Certified Emergency personnel (first responders, emergency medical technicians, paramedics) and/or a licensed physician.

I agree to be financially responsible for the costs for any medical care/treatment that is not covered by HCSO, at HCSO's sole discretion, or by any privately subscribed insurance. This includes, but is not limited to any transportation costs.

By signing below, I hereby warrant that I am 18 years old or more and competent to enter into this Authorization for Medical Treatment and that I have completely read and fully understand this document and agree to be bound thereby.

_____	_____	_____
Name of Student/Child	Signature of Student/Child	Date
_____	_____	_____
Name of Parent/Legal Guardian	Signature of Parent/Legal Guardian	Date
_____	_____	_____
Name of Parent/Legal Guardian	Signature of Parent/Legal Guardian	Date

** If the Student/Child is 17 years old or younger, Parent/Legal Guardian signature(s) are required **

This Authorization for Medical Treatment having been SWORN TO AND SUBSCRIBED before me this _____ day of _____, 20____, by _____, who was personally known_____ or who produced _____ as identification.

_____

Notary Public, State of Florida at Large

Print Name: _____

My Commission Expires: _____