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: ______________