HILLSBOROUGH COUNTY SHERIFF'S OFFICE

BUILDING 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:

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(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:

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

If "Yes" please describe in detail:

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(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:

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____

(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.

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Notary Public, State of Florida at Large

Print Name: _____________________________

My Commission Expires: _________________