

HILLSBOROUGH COUNTY SHERIFF'S OFFICE
BUILDING STARS 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)?

<u>Medical Condition</u>	<u>Past</u>		<u>Present</u>	
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 **

