

**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)?*

<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 \**

**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: \_\_\_\_\_