

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 _____
Asthma	Yes _____	No _____
Back Injuries	Yes _____	No _____
Broken Bones	Yes _____	No _____
Chest Pain/Palpitations	Yes _____	No _____
Diabetes	Yes _____	No _____
Drug Reactions	Yes _____	No _____
Epilepsy/Seizures	Yes _____	No _____
Headaches	Yes _____	No _____
Hearing Problems	Yes _____	No _____
Heart Attack	Yes _____	No _____
Heart Disease	Yes _____	No _____
High Blood Pressure	Yes _____	No _____
Knee Injuries	Yes _____	No _____
Neck Injuries	Yes _____	No _____
Stroke	Yes _____	No _____
Thyroid Disorder	Yes _____	No _____
Vision Problems	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: