

**HILLSBOROUGH COUNTY SHERIFF'S OFFICE  
RISING STARS LEADERSHIP ACADEMY**

**EMERGENCY NOTIFICATION FORM**

Student's High School: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Address, City, State, Zip

Home Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

***Mother/Guardian***

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Address, City, State, Zip Code

Employer Name & Address: \_\_\_\_\_  
Address, City, State, Zip Code

Home Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Telephone: \_\_\_\_\_ Email Address: \_\_\_\_\_

***Father/Guardian***

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Address, City, State, Zip Code

Employer Name & Address: \_\_\_\_\_  
Address, City, State, Zip Code

Home Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Telephone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Are you subject (past or present) to any of the following conditions?

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

Do you have any other medical conditions (past or present) which were not listed above?  
 Yes?  No?

If you answered YES to this question, please describe in detail:

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List any allergies or other medical conditions the Hillsborough County Sheriff's Office should know about:

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Please list any food allergies or food restrictions the student may have:

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List any medication(s) currently prescribed:

Medication	Condition	Dosage	Frequency

Primary Care Physician:

Telephone:

Address:

Address, City, State, Zip Code

***\* A copy of your current insurance card (front & back) is required as part of this Medical Profile form.***

***CERTIFICATION***

I certify that the information provided herein as part of the Medical Profile is true and accurate.

Signature:

Date:

Applicant Signature

Signature:

Date:

Parent/Guardian Signature

Signature:

Date:

Parent/Guardian Signature

***\* If applicant is 17 years of age or younger, parent/guardian signature is required in addition to applicant.***

**HILLSBOROUGH COUNTY SHERIFF'S OFFICE  
RISING STARS LEADERSHIP ACADEMY**

*Authorization for Medical Treatment*

I, the undersigned, as parent/guardian of the listed minor child hereby request that the Hillsborough County Sheriff's Office notify, if possible, the person(s) listed on the Medical Profile in the event of illness, injury, or medical emergency. In the event the listed person(s) cannot be reached or if the listed minor child requires immediate medical treatment, I hereby authorize the Hillsborough County Sheriff's Office, specifically Sheriff's Office personnel to include sworn and civilian, to seek immediate medical treatment, to include transportation by ambulance if necessary, of the listed minor child to a medical treatment facility. Additionally, I authorize the Hillsborough County Sheriff's Office, Sheriff's Office personnel to include sworn and civilian, to consent on my behalf to any medication, x-ray examination, anesthetic, injection, medical or surgical diagnosis or treatment, to include any medical procedure and/or hospital care deemed necessary or advisable by Certified Emergency personnel (first responder, emergency medical technician, paramedic) and/or licensed physician, to eliminate said medical condition or medical emergency for the listed minor child.

I do hereby agree to be financially responsible for any medical treatment to include transportation, not covered by Hillsborough County Sheriff's Office, or privately subscribed insurance.

Signature: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Applicant Signature

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian Signature

Printed Name: \_\_\_\_\_  
First, Middle, Last

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian Signature

Printed Name: \_\_\_\_\_  
First, Middle, Last

NOTARY SEAL

Signed before me this \_\_\_\_\_ day of \_\_\_\_\_, 2019

\_\_\_\_\_  
Signature, Notary Public, State of Florida at Large My Commission Expires

Personally Known Or  Produced Identification ID Produced: \_\_\_\_\_