



Round Rock Police Department

ROUND ROCK POLICE DEPARTMENT JUNIOR POLICE ACADEMY APPLICATION

MEDICAL INFORMATION

PLEASE PRINT

Date: _____

Name of Participant: _____ Date of Birth: _____

Please list ANY medical conditions that the participant has? _____

List ALL medications taken by the participant? _____

Is the participant required to take medication during the academy hours? Yes _____ No _____
If yes, what is the medication /dosage?

Is the participant able to administer medication? Yes _____ No _____

If no please explain _____

PHYSICIAN _____ PHONE _____

DENTIST _____ PHONE _____

Parent/Guardian _____

Address _____

Cell Phone _____ Home Phone _____

Employer _____ Phone _____

NOTE: All medical emergencies will be treated as such and will be attended to by the Round Rock Fire Department as deemed necessary by academy personnel, instructors, or coordinators.
