FORSYTH R-III SCHOOL HEALTH OFFICE
P.O. BOX 187
FORSYTH, MO 65653
417-546-6381, EXT. 283 OR 331

Student Name: _____

Date of Birth: _____

Health and Emergency Information Form

Parent/Guardian_____ Daytime Phone _____

Parent/Guardian_____ Daytime Phone _____

If a parent cannot be reached, please list a local contact person who knows your child's medical history and who has permission to authorize treatment if needed:

_____	_____	_____
Name	Phone Number	Relationship
_____	_____	_____
Name	Phone Number	Relationship

Health Care Provider _____ Phone Number _____
Hospital Preference _____
Allergies (medicines, foods, bees, etc.) _____
Health Concerns/Conditions (ADD, asthma, diabetes, injuries, etc.)_____
_____
Current Medications _____

Consent for Emergency Medical Treatment:

I realize that occasionally throughout the school year, children are injured or ill enough to warrant emergency medical attention and that sometimes parents are not available by phone to give prompt permission for treatment. In an effort to expedite emergency treatment for my child in such an event, I authorize Forsyth School District to secure emergency medical aid from trained school personnel and the local ambulance and/or first responder services. I understand that this is applicable only in acute medical emergencies and in situations where delay of treatment is inadvisable.

Signed ___________________________________ Relationship ______________________ Date:

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