CLAYTON
HIGH SCHOOL

Graduation Year _____

CHS Emergency Contact Form

Student's Full Name _____ Phone _____

Sex _____ Age _____ Date of Birth _____ Sport(s)(if any)_____

Address_____

Student's Email Address_____

Insurance Company_____ Policy Holder_____Number _____

Mother's/Guardian's Name_____ Home Phone_____

email:_____ Work Phone_____ Cell_____

Father's/Guardian's Name_____ Home Phone_____

email:_____ Work Phone_____ Cell_____

Student lives with _____Custody Responsibility_____

Persons to be called if above cannot be reached. (please list two names)

Name _____ Relationship _____

Work Phone_____ Cell_____ Home Phone_____

Name _____ Relationship _____

Work Phone_____ Cell_____ Home Phone_____

Allergies (food, meds, bees, other) ☐ No ☐ Yes If yes, list medicines (including epi-pen)

_____

Asthma ☐ No ☐ Yes If yes, list all medicines _____

Please complete both front & back of this form.
Return to Clayton High School Athletic Office by July 1st
REQUIRED EVEN IF YOUR CHILD DOES NOT PLAY SPORTS
#1 Mark Twain Circle, Clayton, MO 63105
314-854-6740 Fax: 314-854-6742 email: debradornfeld@claytonschools.net

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Prescription medicines currently taking (additional to those listed above)

_____

*All students with prescription medication (including epi-pens, inhalers & diabetes medicines) must turn in physician orders to school nurse and athletic department.

Diabetic (if yes, type) _____ Concussion (dates) _____ Last Tetanus _____

Any other information CHS staff should be aware of? (surgeries, illnesses, injuries, etc. include dates)

_____

Student's Primary Physician _____Phone_____

Preferred Hospital _____

Student's Dentist _____ Phone _____

Does this information reflect a change from previous information provided to the school? ☐ No ☐ Yes

If Yes, please list the change(s) _____

Please check medication(s) you consent to Clayton School District to administer to your child:

☐ Acetaminophen (Tylenol) ☐ Ibuprofen (Advil) ☐ Benadryl ☐ Tums

Medical Release: I give my permission for the Clayton High School staff to seek medical treatment for my child in the case of injury or illness that has been incurred while participating in a school sponsored activity and I cannot be reached to give my consent to emergency personnel.

Sharing of Medical Records: I give my permission for the Clayton High School athletic training staff to share pertinent medical information with the coaching staff, team physicians, school nurse and athletic director(s).

I ACKNOWLEDGE THE ABOVE INFORMATION IS CORRECT

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE

Parent/Guardian Signature _____ **Date** _____

Printed _____

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