CareSTL Health

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School-Based Health Centers
☐ Hazelwood School District
☐ Jennings School District
☐ Ritenour School District
☐ Riverview Gardens School District

☐ CareSTL Health
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For more information visit
www.carestlhealth.org

Home of the Warriors
JENNINGS SCHOOL DISTRICT

School-Based Health Services – Authorization to Treat a Minor Child

The School-Based Health Center is a partnership between CareSTL Health and Jennings School District. By completing this form and opting in for services, you are granting permission for the evaluation and treatment of your child. In addition, you are granting permission for the release of information (e.g. grades, attendance records, IEP, 504 plans, and basic health history) from Jennings School District to CareSTL Health. This authorization form will remain on file in your child's medical record for future reference. You reserve the right to revoke this authorization at any time.

☐ I opt in and give permission for CareSTL Health to treat my child and hereby consent to the administration of required vaccines and/or medications determined by the provider to be necessary for the welfare of my child and the following medical/dental care (check all that apply):

- ☐ Immunizations
- ☐ Physical Exams (includes Sports physicals)
- ☐ Assessment, diagnosis and treatment of minor illness and injury
- ☐ Preventative health education
- ☐ Pediatric Dental Care (Available services include fillings, extractions, sealants, crowns, and silver diamine fluoride as needed)

☐ I opt in and give permission for CareSTL Health to treat my child and hereby consent to any behavioral health services and/or counseling determined by the provider to be necessary for the welfare of my child.

☐ I opt out. I do not want CareSTL Health to treat my child for medical, dental, or behavioral health services.

Child's Name _____ DOB _____ School Name _____

Parent/Legal Guardian Authorization and Contact Information:

Name _____ Phone # _____
Address _____
Signature _____ Date _____

PLEASE COMPLETE: MEDICAL HISTORY

Date of Last Physical _____ Date of Last Dental Exam _____
Allergies (Food or Drug) _____
Past Medical Illness/Surgical History _____
_____
Child's Primary Doctor (if any)_____ Phone # _____
Insurance Plan _____ Policy Number _____
Primary Subscriber _____ Group # _____
Dental Insurance Plan _____ Preferred Pharmacy _____

For CareSTL Health Staff Use Only:

I attest that the medical history has been completed. Signature _____ Date _____