CareSTL Health

☐ **CareSTL Health - Headquarters**
5471 Dr. Martin Luther King Drive
Saint Louis, Missouri 63112
Office: 314.367.5820 Fax: 314.367.7010

☐ **CareSTL Health**
5541 Riverview Boulevard
Saint Louis, Missouri 63120
Office: 314.389.4566 Fax: 314.389.5514

☐ **CareSTL Health**
4500 Pope Avenue
Saint Louis, Missouri 63115
Office: 314.385.3990 Fax: 314.389.2464

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

☐ **CareSTL Health**
2425 Whittier Street
Saint Louis, Missouri 63113
Office: 314.371.3100 Fax: 314.289.8718

For more information visit...
www.carestlhealth.org

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

School-Based Health Services is a partnership between CareSTL Health and _____.
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 _____ 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
- ☐ Pediatric Dental Care (Available services include fillings, extractions, sealants, crowns, and silver diamine fluoride as needed)
- ☐ Physical Exams (includes Sports Physicals)
- ☐ Assessment, diagnosis and treatment of minor illness and injury

☐ 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.

School_____ **Child's Name** _____

DOB _____ **Language** _____ **Birth Sex** ☐ M or ☐ F

Sexual Orientation ☐ Lesbian or gay ☐ Straight or heterosexual ☐ Bisexual ☐ Do not know ☐ Choose not to answer ☐ Other: _____

Gender Identity ☐ Male ☐Female ☐ Female-to-Male ☐ Male-to-Female ☐ Genderqueer, neither male nor female ☐ Choose not to answer ☐ Other: _____

Ethnicity ☐Hispanic/Latino ☐Non-Hispanic/Latino **Race** ☐ Black ☐White ☐ Asian ☐ American Indian ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Parent/Legal Guardian Authorization and Contact Information:

Name _____ **Phone #** _____
Address _____
Email 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 _____

CareSTL Health – Accompany a Minor Consent

In the event your student is referred to one of CareSTL Health's main healthcare facilities for additional services you may provide permission for individuals other than yourself to accompany student to appointment. Please list anyone whom you give permission below:

_____	_____
Name	Relationship to Student
_____	_____
Name	Relationship to Student
_____	_____
Name	Relationship to Student
_____	_____
Name	Relationship to Student
_____	_____
Name	Relationship to Student