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School-Based Health Centers

- Hazelwood School District
- Jennings School District
- Ritenour School District
- Riverview Gardens School District

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



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

The School-Based Health Center is a partnership between CareSTL Health and Riverview Gardens 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 Riverview Gardens 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):

- | | |
|--|--|
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Preventative health education |
| <input type="checkbox"/> Physical Exams (includes Sports) | <input type="checkbox"/> Pediatric Dental Care |
| <input type="checkbox"/> 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.

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 _____ 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 _____