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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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[www.carestlhealth.org](http://www.carestlhealth.org)



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

School-Based Health Services is a partnership between CareSTL Health and Ritenour 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 Ritenour 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
  - 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** \_\_\_\_\_

**Gender at birth**  M or  F **DOB** \_\_\_\_\_ **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** \_\_\_\_\_

**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 \_\_\_\_\_