☐ **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 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 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 _______________