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

All forms must be completed entirely in order for consent to be honored

School-Based Health Services is a partnership between CareSTL Health and _____ 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 _____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.

You have the right to give an "Informed Consent" prior to the start of any procedure and/or treatment. You will be given all necessary information, so that you can make an informed decision and will be made aware of all "Medically Significant" alternatives. While you may opt in to the below services, a provider from CaresSTL Health must still reach out to you to discuss the treatment options prior to delivery for any services beyond preventive services, such as an immunization, sports physical or general cleaning.

☐ I opt in and give permission for CareSTL Health to treat my child and hereby consent to:
- ☐ Administration of required immunizations
- ☐ Administration of Medications determined by the provider
- ☐ Physical Exams (including Sports and Annual Physicals)
- ☐ Assessment, diagnosis and treatment of illnesses and injury

☐ I opt in and give permission for CareSTL Health to treat my child and hereby consent to: 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 in and give permission for services to be provided through the telehealth system and entered into the electronic health record (treatment will be limited to my child having a photo on file)

☐ I opt in and give permission for CareSTL Health to treat my child and hereby consent to use of a translator to assist with effective communication in my child's preferred language

Child's Information

School Name_____

Child's Last Name _____ **Child's First Name**_____ _____

Home Address _____

City_____**State:**_____**Zip Code:**_____

Primary Phone # _____(____)_____-_____ **Alternate Phone #** ___(____)_____-_____

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Email Address: _____

Date of Birth Month_____Day_____Year_____ **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: _____

Preferred Language _____

Ethnicity ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Unreported/Chose not to disclose ethnicity

Race ☐ Black/African American ☐White ☐ Asian: Please Specify _____ ☐ American Indian/Alaska Native ☐ Native Hawaiian ☐Pacific Islander: Please Specify _____ ☐More than one race ☐Unreported/Chose not to disclose race☐ Other: _____

Special Populations ☐ Homeless ☐ Veteran ☐ Public Housing ☐ Seasonal ☐ Migrant

HEALTH INSURANCE

Do you currently have insurance: ☐ Yes ☐ No

If yes, please provide your insurance information below:

Insurance Plan _____Policy Number _____

Primary Subscriber Name_____Group # _____

Dental Insurance Plan _____ Policy Number _____

Primary Subscriber Name_____Group # _____

MEDICAL/DENTAL HISTORY

Date of Last Health Physical _____

Child's Primary Doctor (if any) _____Phone # (___)_____-_____

Allergies (Food or Drug) _____

Past Medical Illness/Surgical History _____

Date of Last Dental Exam _____

Child's Dental Provider (if any)_____Phone # (___)_____-_____

Parent/Legal Guardian Authorization and Contact Information:

Last Name_____ **First Name**_____

Relation to Patient ☐ Parent/Legal Guardian ☐ Self

Primary Phone # _____(____)_____-_____ **Alternate Phone #** ___(____)_____-_____

Email Address: _____

Signature: _____**Date** ___/___/____

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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

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