FLORIDA DEPARTMENT OF JUVENILE JUSTICE

HEALTH STATUS CHECKLIST

Date: ______________

Program: ____

Provider: ____

Youth Name: ____________________ JJIS#: ______________

A. SCREENER'S OBSERVATIONS:

	Yes	No
1. Youth has obvious injury (Please indicate on body diagram) If yes, describe ______________	☐	☐
2. Youth appears ill If yes, describe ______________	☐	☐
3. Youth has difficulty moving If yes, describe ______________	☐	☐
4. Youth has visible abrasions, cuts or bruises If yes, describe ______________	☐	☐

B. YOUTH INTERVIEW:

CURRENT STATUS

	Yes	No
1. Do you have any health complaints such as injuries, sickness or pain at the present time? If yes, describe ______________	☐	☐
2. (For females) Are you pregnant or suspect that you might be pregnant?	☐	☐

CHRONIC HEALTH PROBLEM

1. Do you have any of the following health problems?

	Yes	No
Diabetes	☐	☐
Asthma	☐	☐
Seizures	☐	☐
Heart Problems	☐	☐
Sickle Cell Disease	☐	☐
Cancer	☐	☐
Tuberculosis	☐	☐

Youth Name: ______________________________ JJIS#: ________________

MEDICATION

	Yes	No
1. Are you taking any medication?		

If Yes, list (include over the counter medication) ______________________

2. Specifically, do you take any of the following:

	Yes	No
Insulin		
Seizure Medication		
Asthma Medication		
Heart Medication		
Birth Control Pills		
Tuberculosis Medication		
Antibiotics		

C. MEDICAL ALERT REVIEW

Youth has a medical alert ☐ Yes ☐ No

D. INTERVENTION AND DISPOSITION

		Yes	No
1.	On-site minor first aid		
2.	Emergency Transfer		
3.	Designated Health Authority Notified		
4.	On-site medical/nursing assessment		
5.	No intervention needed		
6.	Notification made that youth is receiving prescribed medication		

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Printed Name of Person Completing Checklist

______________________________ ______________ ______________

Signature and Title of Person Completing Checklist Date Time

Referred to Licensed Health Care Provider: (Provide healthcare provider's name and reason for referral)

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