FLORIDA DEPARTMENT OF JUVENILE JUSTICE

SICK CALL REQUEST

YOUTH: Please fill in the following information as clearly as possible.

NAME OF YOUTH: _____ **DJJID#:** _____ **DOB:** _____

Facility Name: _____

Male ❑ **Female** ❑ **Date of Request:** _____/_____/_____

Request for: ❑ MEDICAL CARE ❑ DENTAL CARE ❑ MENTAL HEALTH CARE

Please describe your problem:

_____

_____

YOUTH: Please do not write below this line.

TRIAGE: ❑ RN ❑ ARNP/PA ❑ Dental Hygienist ❑ Mental Health Staff
❑ LPN ❑ Physician ❑ Dentist ❑ Other *Date Received*_____

DISPOSITION:

Subjective:_____

_____

_____

Objective: BP: _____Pulse: _____Temp: _____Respirations: _____ Weight: _____

_____

_____

_____

Assessment: _____

_____

_____

Plan (Indicate if per protocol):_____

_____

_____

Date Seen: _____/_____/_____ Time: _____ ☐a.m. ☐p.m.

Person completing form: _____ _____
Printed Name (Licensed Staff) Signature/Title Facility

RN Review: _____
RN Name: _____ RN Signature: _____ Date: _____

Youth Signature: _____