INITIAL HEALTH SCREEN

Youth Name:	Case No.:	
Date:	Time:	Age:

Is this the first time you have been arrested? Yes / No or detained? Yes / No

1) Health Screen

Are you currently being treated for an illness or injury? Yes / No
Are you sick right now? Yes / No
Do you have an untreated injury? Yes / No
Do you have any infections, communicable diseases, rashes, or unexplained itching? Yes / No
Is there any reason you need to see a doctor or nurse immediately? Yes / No
Have you ever been under the care of a psychiatrist, therapist, or mental health professional? Yes / No

If you answered ***YES*** to any of the above, please explain:

Females Only: Are you pregnant, or suspect you might be pregnant? Yes / No | Last menstrual cycle:

Do you have any of the following?

	Epilepsy (seizures)		Tuberculosis		Teeth Problems		Frequent Headaches		Anger Problems
	Diabetes		Mononucleosis		Eye Problems		Skin Problems		Back/Joint Problems
	Asthma		Panic/Anxiety Attack		Ear Problems		Heart Problems		Breathing Problems
	Hepatitis		Blood Disorders		Mood Swings		Stomach Problems		Other
	Diarrhea		Kidney Problems		Depression		Sleeping Problems		

Are you using any prescribed medications for these or any other conditions? Yes / No

- If yes, is the medication(s) with you? Yes / No
- Name of medication(s):

1.	Dosage:
Purpose:	Have you missed a dose? Yes / No
2.	Dosage:
Purpose:	Have you missed a dose? Yes / No
3.	Dosage:
Purpose:	Have you missed a dose? Yes / No
4.	Dosage:
Purpose:	Have you missed a dose? Yes / No

Are you using an over-the-counter medication? If yes, is the medication with you? Yes / No

- Name of over-the-counter medication(s):

1.	Dosage:	Purpose:
2.	Dosage:	Purpose:
3.	Dosage:	Purpose:

Are you allergic to any medications? Yes / No

If yes, what medications?

Are your immunizations (shots) up to date? Yes / No

Do you have any allergies, e.g. nuts, gluten, dairy or insects? Yes / No

If yes, what?

Are you on any special diet? Yes / No

How long? If yes, explain:

Is there additional information you'd like to share with staff to ensure your safety, welfare, and protection? Yes / No

If yes, please explain:

2) Observations by Intake Worker

Does the youth appear to be intoxicated or withdrawing from drugs or alcohol? Yes / No

Are there visible signs of alcohol or drugs? Yes / No

If yes, please explain:

Does the youth have any obvious pain or injury? Yes / No

If yes, what?

Does the youth have any of the following?

	body deformities		trauma markings		bruises		cuts		jaundice
	skin rashes		tattoos		piercings		If yes, explain:		

Does the youth appear to be (check all that apply)

	confused		ill		disoriented		irrational		aggressive
	paranoid		feeling severe shame, guilt, or depression				If yes, explain:		

Does the youth appear to be exhibiting abnormal behavior? Yes / No

Staff comment:

***Any concerns or additional information from parents, Case Manager, court or transport staff?**

If yes, please explain:

Staff Completing the Screening:	***Date:***

(Place one copy in the youth's file and one copy in medical file)