FLORIDA DEPARTMENT OF JUVENILE JUSTICE

REFUSAL OF TREATMENT FORM

NAME OF YOUTH : _____ **DATE:** _____

DATE OF BIRTH: _____ **DJJID#:** _____

I, _____knowing that I have a condition requiring
Name of Youth
medical treatment and care, and having been informed of the benefits of the prescribed care, I willingly have decided for myself to:

PLEASE CHECK ALL APPLICABLE BOXES:

**Please provide details of test, medication, appointment refused etc.

- ❑ Refuse Medication
- ❑ Refuse Dental Care
- ❑ Refuse Off-Site Appointment
- ❑ Refuse Laboratory Services
- ❑ Refuse Immunization
- ❑ Refuse X-Ray Service
- ❑ Refuse Other Diagnostic Test
- ❑ Refuse Physical Examination
- ❑ Refuse Tuberculosis Skin Test
- ❑ Other (Specify)

Reason for Refusal: _____

Benefits and potential consequences of refusal (i.e. worsening of medical condition, etc.) explained to the youth:

_____

NOTIFY DESIGNATED HEALTH AUTHORITY OR PSYCHIATRIST OF ALL MEDICAL/MENTAL HEALTH TREATMENT REFUSALS.

Designated Health Authority or Psychiatrist Notified: ❑Yes ❑No

Response: _____

_____ _____
Youth Signature Date

_____ _____
Nurse/Staff Signature - Date

_____ _____
Witness Signature Date

Rule 63M-2.032, F.A.C. April 2024