



FLORIDA DEPARTMENT OF JUVENILE JUSTICE

SICK CALL REQUEST FORM

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

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

Facility Name: _____ Date of Request: ____/____/____

Request for: ☐ MEDICAL CARE ☐ DENTAL CARE ☐ If this request is related to a mental health concern, please utilize the Mental Health/Substance Abuse Referral form (MHSA014)

Please describe your problem:

YOUTH: Please do not write below this line.

TRIAGE:	RN	APRN/PA	LPN	Physician	Date and Time Received _____
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Subjective:

Objective: BP: _____ Pulse: _____ Temp: _____ Respirations: _____

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: _____

