FACILITY ENTRY PHYSICAL HEALTH SCREENING

Name of Youth: ______________________________ **DJJID#:** ____________

Facility Name: ______________________________ **Date of Birth:** ____________

Age: ____ **Race:** ________ **Sex:** ________ **Eyes:** ________ **Hair:** ________

Parent/Guardian: ____

Address: ______________________________ **Home Phone:** ____________

City/State/Zip: ______________________________ **Work Phone:** ____________

Email: ______________________________ **Cell Phone:** ____________

	NO	YES
1. Youth has obvious injury (Please indicate on body diagram)? If yes, describe:	❑	❑

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Scale (circle level of pain/illness, 1 being the least): 1 2 3 4 5

Screener instructions: If the level of pain/illness is 3 or above, an immediate referral to a Physician/ARNP/PA must be made.

	NO	YES
2. Youth appears intoxicated or under the influence of drugs: If yes, describe:	❑	❑

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Screener instructions: A "yes" response to question 2 requires you to notify the person in charge of the facility at the time. Youth who are intoxicated or under the influence must be taken to a hospital or mental health facility.

	NO	YES
3. Youth appears ill? If yes, describe:	❑	❑

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Scale (circle level of pain/illness, 1 being the least): 1 2 3 4 5

Screener instructions: If the level of pain/illness is 3 or above, an immediate referral to an Physician/ARNP/PA must be made.

	NO	YES
4. Youth appears to have a possible developmental delay? If yes, describe:	❑	❑

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Screener instructions: A "yes" response to question 4 requires that you notify the Program Director/Facility Superintendent and the Mental Health staff person.

Tuberculosis Symptom Screening (Tier I) – Interview with Youth

	NO	YES
1. Are you coughing up blood?	❑	❑

Screener instructions: A "yes" response to question 1 requires an immediate referral to the Designated Health Authority for assessment and/or emergency transfer to the hospital.

	NO	YES
2. Do you have a cough which has lasted longer than 3 weeks and which you cough up anything (green, yellow, red mucous, phlegm, etc.)	❑	❑

Screener instructions: A "yes" response to question 2 requires you to notify the person in charge of the facility at the time.

3. Are you now or have you recently had any of the following:	NO	YES
➢ A fever (greater than 101)?	❑	❑
➢ Weight loss without dieting? # Pounds _______	❑	❑
➢ Fatigue (easy tiring)?	❑	❑
➢ Night or early evening sweats?	❑	❑

Screener instructions: A "yes" response to question 2 plus any three of the symptoms listed in question 3 requires that you do not place the youth into the general population until medically evaluated by an Physician/ARNP/PA. The youth should be isolated or taken outside of the facility (escorted by an officer) until an evaluation can be made. Transportation of the youth to the ER for an XRAY that can be read and interpreted should take place as soon as possible. If coughing, the youth should be instructed to cough directly into tissue, and this should be disposed of in a bio-hazardous container with a lid. If the youth refuses or cannot follow these measures, a mask may be placed on the youth as long as it does not impair his/her ability to breathe. Transporting staff may wear masks at their own discretion. The hospital or CHD must be telephoned in advance (while the youth is in transit). If taken to the ER, the report from the ER should be taken back to the facility with the youth.

	NO	YES
4. Are you now or have you been in the past, an IV drug user or skin injector of any sort?	❑	❑
5. Has anyone with whom you have been living been recently diagnosed with tuberculosis?	❑	❑

Screener instructions: Unless the youth requires immediate intervention as described in #1, 2 and 3, a "yes" response to either question 4 or 5 requires you to notify the Designated Health Authority or the Program Director/Facility Superintendent that youth must be medically evaluated for tuberculosis within 24 hours.

General Physical Health Screening – Screener's Observations

	NO	YES
1. Youth has difficulty moving and/or has a physical handicap? If yes, describe:	❑	❑
2. Youth appears to have a vision, hearing, or speech impairment? If yes, describe:	❑	❑
3. Youth has evidence of lice, scabies, etc.	❑	❑
4. Youth has visible scars (check wrists), tattoos, other skin markings, or piercing? If yes, describe: (See note on piercings on last page)	❑	❑

Current Status – Youth Interview

	NO	YES
1. Do you have any health complaints such as injuries, sickness, or pain, at the present time? If yes, describe:	❑	❑
2. Have you had a recent injury? If yes, describe how this occurred, when and where:	❑	❑
3. Specifically, have you had a recent head injury? If yes, describe how this occurred, when and where:	❑	❑
4. For females: Are you pregnant or suspect that you might be pregnant?	❑	❑

5. Do you have, or have you ever had, any of the following health problems:

	NO	YES	
		PAST	PRESENT
Adrenal Insufficiency	❑	❑	❑
Alcohol or Drug Use	❑	❑	❑
Asthma	❑	❑	❑
Cancer	❑	❑	❑
Cardiac Arrhythmias, Disorders or Murmurs	❑	❑	❑
Child Birth: Post Partum in Past Two Weeks	❑	❑	❑
Diabetes	❑	❑	❑
Head Injury: Within Past Two Weeks	❑	❑	❑
Hearing, Speech, or Visual Deficits	❑	❑	❑
Heart Problems or Chest Pain When Exercising	❑	❑	❑
Hemophilia (Bleeding Disorder)	❑	❑	❑
Hepatitis	❑	❑	❑
High Blood Pressure (Hypertension)	❑	❑	❑
History of Anaphylaxis: Use of EpiPen	❑	❑	❑
HIV/AIDS	❑	❑	❑

	NO	YES	
		PAST	PRESENT
Hypo or Hyperthyroidism	❑	❑	❑
Kidney Failure (with or without Dialysis)	❑	❑	❑
Lice/Scabies/Crabs	❑	❑	❑
Neuromuscular Conditions: Cerebral Palsy, Muscular Dystrophy, Multiple Sclerosis	❑	❑	❑
Pregnancy	❑	❑	❑
Seizures	❑	❑	❑
Sickle Cell Disease (Anemia)	❑	❑	❑
Sickle Cell Trait	❑	❑	❑
Spina Bifida	❑	❑	❑
Systemic Lupus Erythematosis	❑	❑	❑
Thyroid Problems	❑	❑	❑
Tuberculosis	❑	❑	❑

*****NOTE: ALL YES PRESENT RESPONSES REQUIRE NOTIFICATION OF THE DESIGNATED HEALTH AUTHORITY.***

Current Medications – Youth Interviews

	NO	YES
1. Are you taking any medication for mental conditions (behavior/emotions) or physical health? If yes, list and include over-the-counter medication if any:	❑	❑

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2. Specifically, do you take any of the following?	NO	YES	Date/Time of Last Dosage
Insulin	❑	❑	
Seizure Medication	❑	❑	
Asthma Medication	❑	❑	
Heart Medication	❑	❑	
Tuberculosis Medication	❑	❑	
Folic Acid	❑	❑	

NOTE: IF YES TO ANY ABOVE, PLACE YOUTH ON MEDICAL ALERT!

	Home	Parent	With Me
3. If you take any of the medications listed above, where are they?	❑	❑	❑

NOTE: NOTIFY DHA OR DESIGNEE IF YOUTH DOES NOT HAVE MEDICATION WITH THEM.

	YES	NO
4. Are you allergic to any medications, foods, or other substances? If yes, list:	❑	❑

Medications	**Foods**	**Other**

NOTE: IF ANY ALLERGIES ARE INDICATED, PLACE YOUTH ON MEDICAL ALERT!

Physical Health Disposition

1. ❑ Emergency health treatment needs due to injury or illness: institute on-site procedures and call "911".
2. ❑ Possible active tuberculosis: institute transportation to hospital or county health department for evaluation if MD/ARNP/PA not immediately available.
3. ❑ Youth appears intoxicated or under the influence of other non-medical substances (cocaine, crack, LSD etc.): Institute procedures for transportation to hospital or appropriate mental health facility for emergency treatment and/or evaluation.
4. ❑ Schedule sick call appointment (put on list).
5. ❑ Schedule physician referral appointment (put on list).
6. ❑ No complaints or evidence of illness:
   Schedule for Comprehensive Physical Assessment, if needed. ☐ Yes ☐ No
7. ❑ Unsure as to action. Contact Designated Health Authority or shift supervisor per facility operating procedures to determine action.

Note: For Piercings If youth knows how to remove, he/she should remove. If on body (not tongue), area needs to be cleansed regularly with antibacterial soap. No ointment. If oral piercing, youth should remove and mouthwash should be used. If labial, penile or other genital piercing, only an MD/PA/ARNP should remove.

NOTE: SEE ATTACHED BODY CHART FOR VISUAL BODY SKIN SCREENING

Facility Staff Screener Signature	Licensed Health Care Reviewer Signature (LPN/RN/ARNP)
Facility Staff Printed Name	Licensed Health Care Reviewer Printed Name
Title/ Position	Title/ Position
Date	Date

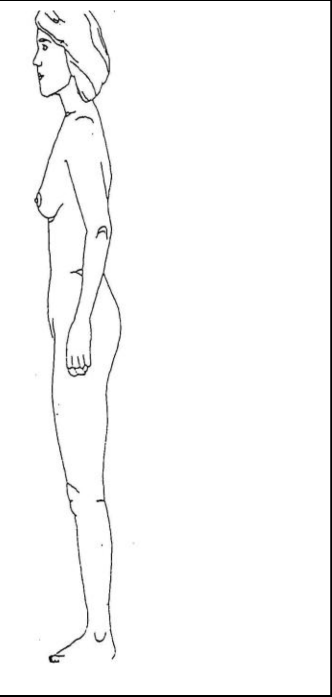
Note: Licensed health care staff shall review this document if performed by facility (non-health care) staff.

FEMALE BODY CHART

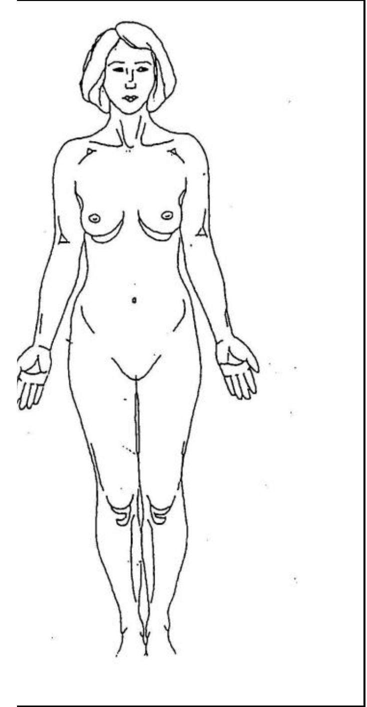
Youth Name:______________________ Staff Name:______________________

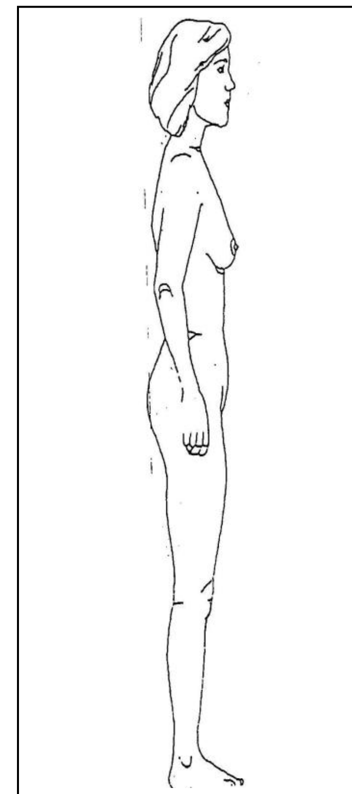
DJJID#:______________________ Date:______________________

Time:______________________

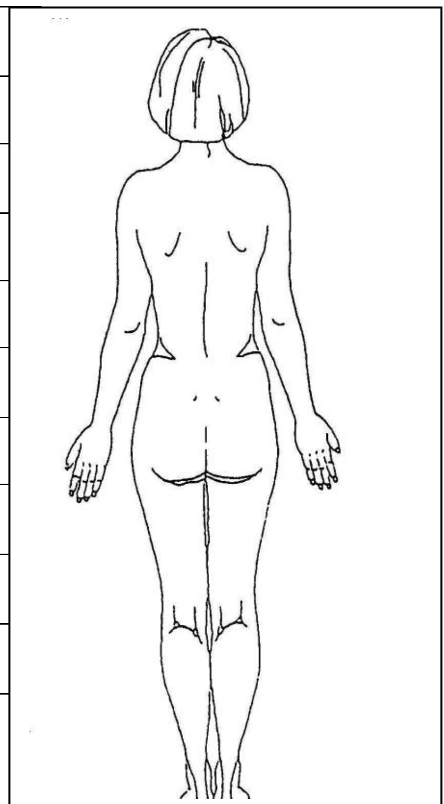


Identifying Marks	Position	Location





Identifying Marks	Position	Location

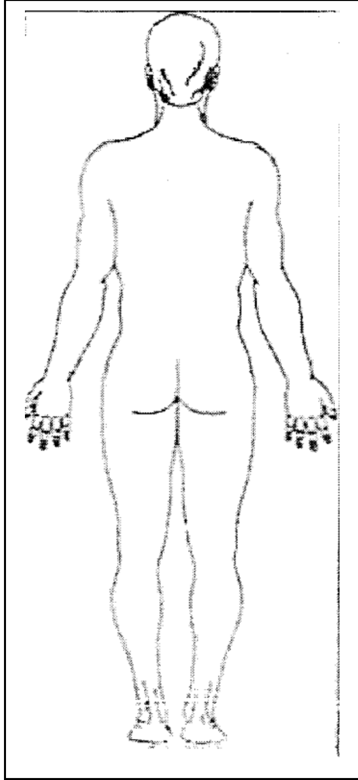


MALE BODY CHART

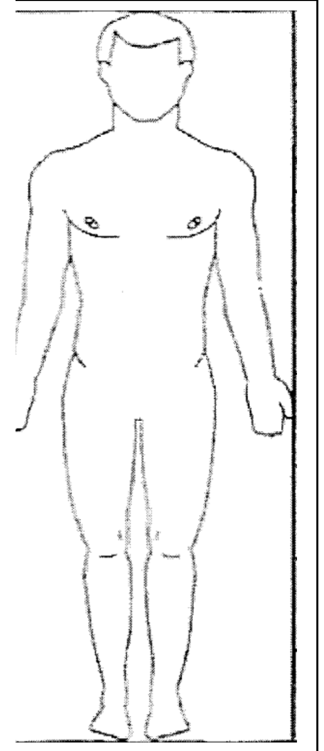
Youth Name:______________________________ Staff Name:______________________________

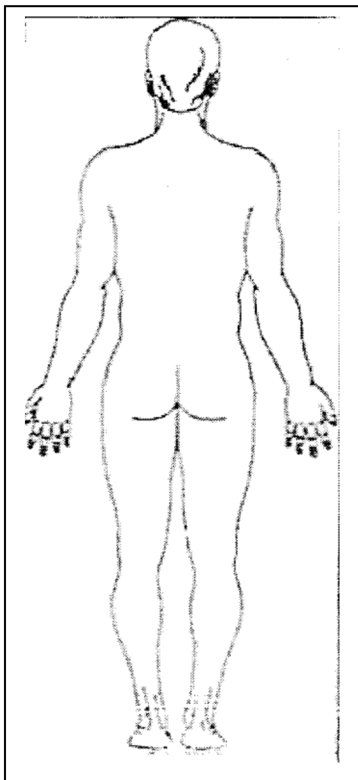
DJJID#:______________________________ Date:______________________________

Time:______________________________



Identifying Marks	Position	Location





Identifying Marks	Position	Location