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: _____ **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* _____

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: _____

Save As | Reset/Clear Form | Print Form