

HAMILTON COUNTY JUVENILE DETENTION CENTER
MEDICAL & MENTAL HEALTH INFORMATION
CONSENT FOR MEDICAL TREATMENT

JUVENILE'S NAME: _____

SEX _____ DOB _____ AGE _____ HEIGHT _____ WEIGHT _____

PARENT/GUARDIAN: _____

MOBILE # _____ WORK TEL # _____

FAMILY PHYSICIAN: _____ TEL# _____

DENTIST: _____ TEL # _____

INSURANCE CARRIER: _____

INSURANCE OR MEDICAID POLICY NUMBER: _____

MEDICAL & MENTAL HEALTH HISTORY

Please answer *YES* or *NO* to the following questions. All **YES** responses need to be fully explained in the comments line.

IS THE CHILD:

COMMENTS

- | | |
|---|--|
| 1. Currently under a physician's care? | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| 2. Currently taking any medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| 3. Currently wearing glasses or contacts? | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| 4. Allergic to any food or medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| 5. User of tobacco products? | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| 6. Pregnant or suspected of being pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |

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IS THE CHILD SUBJECT TO:

COMMENTS

7. Bedwetting? Yes No _____

8. Convulsions or seizures? Yes No _____

9. Asthmatic or other respiratory conditions? Yes No _____

HAS THE CHILD:

COMMENTS

10. Been recently exposed to any communicable diseases? Yes No _____

11. Been hospitalized (in the last 3 months)? Yes No _____

12. Had surgery? Yes No _____

13. Been restricted from any physical activity or exercise program? Yes No _____

14. Had any recent injuries requiring medical attention? Yes No _____

15. Had any recent illness lasting more than one week? Yes No _____

16. History of venereal disease or abnormal discharge? Yes No _____

17. Been treated for any mental health problems? Yes No _____

18. Experienced suicidal thoughts or made any attempt(s) of suicide? Yes No _____

PLEASE LIST THE DATES OF THE MOST RECENT:

Tetanus shot _____ Date _____ Result Pos Neg _____

TB skin test _____ Date _____ Result Pos Neg _____

Hepatitis B (3 shot series) Dates: _____, _____, _____

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CONSENT FOR MEDICAL TREATMENT

1. I, _____parent/legal guardian of the minor,
_____, do hereby give permission for the personnel of the Hamilton County Juvenile Services Center to take said minor child to a doctor or hospital and authorize that person to give consent for treatment and sign authorization on my behalf for any treatment or procedure deemed necessary by the attending physician. I further accept all financial responsibility for costs incurred for treatment.
2. I consent to the release of information (medical, physical, psychological and/or drug and alcohol treatment) for the purpose of continuance of care to any Hamilton County Sheriff's Staff or representative thereof. It is my understanding that this authorization will expire upon the release of my child from the Hamilton County Juvenile Services Center without express written revocation and may be revoked by me in writing at any time prior to the release of my child for the Services Center.

ADDITIONAL COMMENTS

Signed: _____ **Relationship:** _____ **Date:** _____

Witness: _____ **Date:** _____