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: ____

Male ❑ Female ❑ **Date of Request:** ________/_________/________

Request for: ❑ MEDICAL CARE ❑ DENTAL CARE ❑ MENTAL HEALTH CARE

Please describe your problem:

____

____

YOUTH: Please do not write below this line.

TRIAGE: ❑ RN ❑ ARNP/PA ❑ Dental Hygienist ❑ Mental Health Staff
❑ LPN ❑ Physician ❑ Dentist ❑ Other *Date Received*_______________

DISPOSITION:

Subjective:____

____

____

Objective: BP: ________Pulse: ________Temp: ________Respirations: ________ Weight: ________

____

____

____

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: ____________

Youth Signature: ____

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