HAMILTON COUNTY JUVENILE SERVICES CENTER

HEALTH INFORMATION

JUVENILE'S NAME: _____

SEX _____ DOB_____ AGE_____ HEIGHT_____ WEIGHT_____

PARENT/GUARDIAN: _____

HOME TEL #_____ WORK TEL #_____

FAMILY PHYSICIAN: _____ TEL#_____

DENTIST: _____ TEL #_____

INSURANCE CARRIER: _____

INSURANCE OR MEDICAID POLICY NUMBER: _____

MEDICAL HISTORY

Please answer *YES* or *NO* to the following questions. All **YES** responses need to be fully explained on the back of this page.

IS THE CHILD:	**COMMENTS**
1. Currently under a physician's care?	□Yes □No_____
2. Currently taking any medication?	□Yes □No_____
3. Currently wearing glasses or contacts?	□Yes □No_____
4. Allergic to any food or medication?	□Yes □No_____
5. User of tobacco products?	□Yes □No_____
6. Pregnant or suspected of being pregnant?	□Yes □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_____

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. If 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: _____