HEALTH/MEDICAL QUESTIONNAIRE

Admission Date: DOB: Age: Sex: Race:

Name: Height _____ Weight _____

Address: Emergency Telephone # _____

Mother's Employment: Work Phone #:

Father's Employment: Work Phone #:

Guardian's Employment: Work Phone #:

Current Symptoms/Illness: _____

Current Medication/Dosage: _____

Current Medical/Dental Needs: _____

List any allergies: _____

Date of Last Physical Exam: _____ Date of Last Dental Exam: _____

List Past Serious Illnesses: _____

Received Counseling/Psychiatric Care? _____ Where: _____

List any Accidents you had: _____

List Past Operations: _____

In What Hospital: _____

Personal Physician: _____ Telephone: _____

Medical Insurance/Policy No.: _____

Address: _____ Telephone: _____

Medicare Eligible? _____ DNC# _____Policy Terminates: _____

In the Event of Emergency Treatment, I prefer: Hospital: _____

Do You Have -	Asthma: ☐ Heart Trouble: ☐ Convulsions ☐ Fainting: ☐
Do You Need to be Seen by a Doctor for -	Pregnancy: ☐ Sexually Transmitted Diseases: ☐
Do you Have Problems with -	Eyes: ☐ Ears: ☐ Nose: ☐ Throat: ☐ Teeth: ☐ Digestion ☐
	Last Menstruation Period: ☐ Bedwetting: ☐ Sleepwalking: ☐
Have You Had -	Measles: ☐ Mumps: ☐ Chickenpox: ☐ Hepatitis: ☐

PARENT AUTHORIZATION:

I UNDERSTAND THAT MY SON/DAUGHTER MAY RECEIVE A PHYSICAL EXAMINATION BY MEDICAL PERSONNEL WHILE AT THE ROBERT L. PERRY JUVENILE JUSTICE CENTER. I FURTHER UNDERSTAND THAT SHOULD MY CHILD REQUIRE MEDICAL ATTENTION, OR DENTAL TREATMENT BEYOND THAT PROVIDED AT THE ROBERT L. PERRY JUVENILE JUSTICE CENTER, THAT I WILL FIRST BE CONTACTED TO ARRANGE FOR THE NECESSARY MEDICAL CARE. IF I DO NOT ARRANGE FOR THIS CARE, OR IF EMERGENCY CIRCUMSTANCES REQUIRE, THE MEDICAL CARE WILL BE ARRANGED BY ROBERT L. PERRY JUVENILE JUSTICE CENTER STAFF AND I WILL BE RESPONSIBLE FOR FINANCIAL PAYMENT OF CARE AND DRUGS.

Signature of Parent/Guardian Signature of Witness

_____ _____

Date Signed_____