DEPARTMENT OF CORRECTIONS
Division of Juvenile Corrections
DOC-3387 (Rev. 11/99)

WISCONSIN

HEALTH SCREENING—DJC

Screening Type

☐ Sanction ☐ Initial Admission _____ ☐ Other _____

NAME OF YOUTH	J-NUMBER	DATE OF BIRTH

ILLNESS/INJURY	**YES**	**NO**
Does the youth appear ill		
Difficulty breathing		
Evidence of trauma/injury (bleeding, abrasions, contusions)		
Appears under influence of drugs or alcohol		
Any complaints of pain		

MAJOR ILLNESSES	**YES**	**NO**
Heart Disease		
Diabetes		
Seizures		
Asthma		
Handicap/Deformity		
Recently Hospitalized		

Name of Hospital _____ Date: _____

MENTAL CONDITION	**YES**	**NO**
Depressed appearance (crying, etc.)		
Agitated		
Incoherent		
Disoriented		
Suicidal		

ALLERGIES	**YES**	**NO**
Does the youth have any allergies		

List Allergies:

	YES	**NO**
Previous adjudication(s)		

COMMUNICABLE DISEASE	**YES**	**NO**
Tuberculosis		
Hepatitis		

DATE OF LAST:	**Date**
Tetanus/Diphtheria Booster	
TB Test	

PREGNANCY

Due Date _____ Last MD Visit _____

Name of Doctor _____

Phone Number of Doctor _____

MEDICATIONS	**YES**	**NO**
Is youth currently taking		

Name of Medication	Medication Received
	☐ **Yes** ☐ **No**
	☐ **Yes** ☐ **No**
	☐ **Yes** ☐ **No**
	☐ **Yes** ☐ **No**
	☐ **Yes** ☐ **No**
	☐ **Yes** ☐ **No**

Comments:

PARENTAL/GUARDIAN PHONE NUMBER	PARENTAL/GUARDIAN PHONE NUMBER
COUNTY CONTACT FOR HEALTH QUESTIONS	**COUNTY CONTACT PHONE NUMBER**

Attach the following to this form if available:
Last Physical Immunization/TB Testing Other related information such as lab

COMPLETED BY	PHONE NUMBER	DATE COMPLETED

FORM AND MEDICATION MUST ACCOMPANY YOUTH