integrity compassion security respect

youth care center

A continuum of care

Intake Application / Checklist

Out of County Waived Juvenile Arrestee

First Name: _____ Middle Name: _____ Last Name: _____

County: _____ Case Number: _____ Referring Agency Contact: _____

The Youth Care Center requires the following information to be completed and submitted prior to a review hearing and placement:

CHARGING INFORMATION

	Arrest Report
	Probable Cause Affidavit
	Criminal History

FUTURE COURT DATES / APPOINTMENTS

MEDICAL / PSYCHOLOGICAL / SUBSTANCE ABUSE HISTORY

	Complete List of Medications With Directions and Prescriber Information
	Last Drug Screen With Results
	Complete Health Screen
	Prior Evaluations / Mental Health - Psychological History

NOTICE

The Youth Care Center does not provide transportation to or from other counties. Video Court is available.

Per Diem - $209.19

We can not accept individuals with mobility impairment as we are not handicapped accessible.

All documents for admission will be reviewed by our Leadership team prior to acceptance.

ADMISSIONS APPLICATION **DATE OF ARRIVAL: _____**

Resident: _____
(first) (middle) (last)

Address:_____ Apartment #: _____

City: _____ State: _____ Zip: _____

Who is resident currently living with? _____

What is his/her relationship to the youth? _____

Race: _____ Age: ____ Birthdate: _____ Place of Birth: _____
(city, state)

Height: ____ft. _____in. Weight: _____lbs. Hair Color: _____ Eye Color: _____

Religion: _____ Church: _____ Pastor: _____

Name of Legal Guardian: _____ Relationship to Resident: _____

Phone #: _____ Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Describe youth's current relationship with parents/guardians: _____

Biological Father: _____ Birthdate: _____ Deceased: YES / NO (circle one)

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Biological Mother: _____ Birthdate: _____ Deceased: YES / NO (circle one)

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Are parental rights terminated? YES / NO (circle one) Is the resident a ward of the state? YES / NO

Why is the resident a ward of the state? _____

Siblings: NAME AGE RELATION ADDRESS

_____

_____

_____

_____

____

____

*** For additional names, use blank space on back of page.**
Describe youth's relationship with siblings: ____

Other people who may be actively involved with the youth:

Name: ______________________ Relation: _________________ Phone: _____________________

Name: ______________________ Relation: _________________ Phone: _____________________

Name: ______________________ Relation: _________________ Phone: _____________________

Current problems / concerns: ____

What programs or services is the youth currently participating in? _____________________________

What services would benefit the youth? ____

Are there any significant events, such as traumas, deaths or births that have had an impact on the resident's life?

AGE	EVENT

Are youth's guardians willing to be involved in programming? YES / NO (circle one)

Are youth's guardians willing to be involved in future placement of youth? YES / NO (circle one)

~~~~~~

Resident's current school: ________________________________ City / State: ________________________

Is the resident currently expelled from school? YES / NO Date of expulsion: ______________

Reason for expulsion: _________________________ When will the resident return to school? __________

Is the resident currently suspended from school? YES / NO Dates of suspension: ________________

Reason for suspension: ____________________________ Is this the resident's first suspension? YES / NO

Is the resident in special education classes? YES / NO What is the classification? LD / ED / other: ____

Date resident last attended school: ____________ Date of last special education testing: ______________
~~~~~~

~~~~~~

Is youth currently prescribed medication? YES / NO

Is youth currently receiving medication? YES / NO

Does youth take medication consistently and as prescribed? YES / NO

If NO, please explain: ____

Who prescribed youth's medication? __________________ Location of doctor: __________________

MEDICATION	DOSAGE	PURPOSE

Name of youth's doctor: ________________________ Location of youth's doctor: __________________

Does youth wear glasses? YES / NO Does youth wear contacts? YES / NO

Name of youth's eye doctor: ____________________ Location of youth's eye doctor: ______________

Does youth have a specialty doctor for current health problems? YES / NO

Name of specialty doctor: _______________________ Location of doctor: ________________________

Does youth have any family history of tuberculosis? YES / NO

If YES, who and please explain: ____

Has youth been exposed to or had any communicable diseases (scabies, lice, MRSA, tuberculosis, hepatitis, chicken pox, flu, mumps, malaria, herpes, STDs, measles, etc.)? YES / NO?

CONDITION	AGE

Does youth have any health problems? YES / NO Does the youth have a special diet? YES / NO

If YES, please explain: ____
~~~~~~

Does youth have any allergies? YES / NO **Does youth have a food allergy? YES / NO**

If YES, please explain: ____

Does youth have any physical limitations, restrictions, doctors' orders, or special needs? YES / NO

If YES, please explain: ____

Has youth been sexually abused, raped, or molested? YES / NO

If YES, by whom? ____________________ **What age did the event occur? ________________________**

Has youth been placed in any other facilities (detention, residential, etc.)? YES / NO

FACILITY	STATE	DATES	REASON FOR PLACEMENT

Is youth currently in therapy/counseling? YES / NO

Agency providing of therapy/counseling: ____

Name(s) of Therapist/Counselor: ____

As the parent, what are your future placement goals for the youth (detention, residential, home, etc.)?

____

____

What are your goals for your child?

____

____

~~~~~~

Medicaid #: ____________________________________

Insurance Company: ____________________________ **Insurance #: ___________________**

Social Security #: ______________________________

The following must be provided at time of intake:

BIRTH CERTIFICATE
MEDICAID / INSURANCE CARD
SOCIAL SECURITY CARD
SIGNATURES ON "PARENTAL SIGNATURE PACKET"
~~~~~~

***The first three pages of this intake packet are to be explained and handed to the parent / guardian.**

PARENTAL SIGNATURE PACKET

(Staff will explain all signatures to the parent/guardian and the parent/guardian is to sign on all red lines)

Consent For Mentor

I, _____, guardian of the minor, _____, do hereby give permission for my child to periodically connect with community volunteers to form mentoring relationships with my child. I give permission to place a positive role model in my child's life to mentor while in the Youth Care Center, and upon release.

PARENT/GUARDIAN _____DATE:_____

YCC STAFF:_____DATE:_____

CONSENT FOR MEDICAL TREATMENT

I, _____, guardian of the minor, _____, do hereby give permission for personnel of the Youth Care Center to take said minor to a doctor or hospital and authorize that person to give consent for treatment and signature authorization on my behalf for any treatment or procedure necessary by the attending physician. I further accept all financial responsibility for costs incurred for treatment.

PARENT / GUARDIAN _____ DATE: _____

YCC STAFF: _____ DATE: _____

CONSENT FOR MENTAL HEALTH SERVICES

I, _____, guardian of the minor, _____, do hereby give permission for mental health professionals of the Youth Care Center to provide psychological evaluations ordered by the court and counseling as needed. I give permission for these services to be billed to my insurance or Medicaid.

PARENT / GUARDIAN _____ DATE: _____

YCC STAFF: _____ DATE: _____

RELEASE OF INFORMATION

I, ____________________________________, as parent/guardian, hereby give permission for the Youth Care Center to receive any and all information for the care and treatment of ____; who has been placed into their care.

PARENT / GUARDIAN ____ DATE: __________

YCC STAFF: ____ DATE: __________

RESIDENT: ____ DATE: __________

~~~~~~

RANDOM DRUG SCREENS

The [placing agency] VCJC / PCJC of Vanderburgh / Posey County, hereby gives permission to have random drug screening for, ____, a ward of this county, when staff of the Youth Care Center feel that they have justification for doing so.

PARENT / GUARDIAN ____ DATE: __________

YCC STAFF: ____ DATE: __________

~~~~~~

RELEASE OF LIABILITY FOR PERSONAL BELONGINGS

It is understood that the Youth Care Center or its employees are not responsible in case of damage to or loss of personal property, particularly valuables such as jewelry, cell phones, money and similar items. All of the youth's clothing and personal items must be picked up within three weeks of discharge or they will be donated to the clothing bank and/or discarded.

PARENT / GUARDIAN ____ DATE: __________

YCC STAFF: ____ DATE: __________

RESIDENT: ____ DATE: __________

~~~~~~

PERMISSION FOR HAIRCUT

I, ____, guardian of the minor, ____________________________, do hereby give permission for said minor to get a haircut by a licensed cosmetologist.

PARENT / GUARDIAN ____ DATE: __________

YCC STAFF: ____ DATE: __________

~~~~~~

RELEASE OF LIABILITY

For and in consideration of the care and keep of the above named minor child at the Youth Care Center, the undersigned guardian, or custodial of said child does hereby release and discharge the Evansville Rescue Mission, Youth Care Center and Camp Reveal from any and all liability for injury and damage in any manner whatsoever to the minor herein named which may be claimed or demanded by reason of any sickness, distress, casualty, injury or treatment to said minor or any other claim or demand which I may have against the Evansville Rescue Mission, Youth Care Center, Camp Reveal, or officers, directors and/or agents thereof. I further entrust said child to your care and consent to the care and treatment by any duly qualified practicing physician in the event the child becomes ill or is injured to a degree that such treatment seems advisable while said child is at the Youth Care Center and I am not immediately available.

PARENT / GUARDIAN _____ **DATE:** _____

YCC STAFF: _____ **DATE:** _____

Youth Care Center - SAFE/ STAGE Units - 727 Chestnut Street - Evansville, IN 47713
812-421-3806 / 812-421-3807 / 812-421-3804 (fax)

CONSENT FOR RELEASE OF INFORMATION

1.) I hereby authorize the Youth Care Center
727 Chestnut Street
Evansville, IN 47713

to (A) release to _____

(B) receive from _____

(C) exchange with _____

such information as may be necessary regarding the treatment of our session with:

_____	_____	_____
(Client Name)	**(Social Security Number)**	**(Birthdate)**

2.) Information to be disclosed:
- **( ) Information pertaining to substance abuse.**
- **( ) Diagnosis, treatment plan and goals, attendance, progress, clinical impression, personal history, psychosocial situations, and recommendations.**
- **( ) Other: _____**

3.) Purpose of disclosure: ( ) Permit continuity of care ( ) Other: _____

4.) I understand that this consent can be revoked at any time except to the extent that action has been taken in reliance upon it. If I do revoke it, the consent will expire:
- **( ) 90 days after termination of treatment.**
- **( ) Other**

5.) The Youth Care Center and its employees are released from legal liability for the release of the above information to the extent indicated and authorized herein.

_____	_____	_____

(Guardian of Client) **(Relationship to Client)** **(Date)**

_____ _____

(Witness) **(Date)**

Youth Care Center - SAFE/ STAGE Units - 727 Chestnut Street - Evansville, IN 47713
812-421-3806 / 812-421-3807 / 812-421-3804 (fax)

PERMISSION FOR IMMUNIZATION

Resident: _____ DOB: _____

Address: _____

While your child is in placement, it is our responsibility to check immunization records. If we find that he/she is in need of any and they will be placed here for more than a week, the Health Department will come in and give those immunizations. However, on July 1, 2011 their new policy is anyone who has insurance will have to see their private physician. If you have Medicaid or no insurance they will provide immunizations.

1.) **Do you have insurance? YES / NO If yes, what kind: _____**

2.) **Does your child have any allergies, especially to Latex? YES / NO**

Explain: _____

3.) **Does your child have a history of Chicken Pox? YES / NO**

Explain: _____

4.) **Has your child had any severe reactions to previous vaccinations? YES / NO**

Explain: _____

5.) **Do you give permission for your child to receive the required vaccinations? YES / NO**

Tdap (Tetanus, Diphtheria, Whooping Cough)
Chicken Pox Vaccine
Meningitis Vaccine

6.) **Do you give permission for your child to receive the recommended vaccinations which are as follows?**

Human Papillomavirus (HPV) Vaccine
Hep A Series
Meningitis Booster

7.) The HPV and Hep A are a series of shots which would require you to follow up once your child is released. Will you follow up with your child's shots? YES / NO

Parent / Guardian Signature **Date**

Youth Care Center Staff **Date**

Intake Health Screening

ROOM NUMBER		DATE OF BIRTH	
INMATE NAME (LAST, FIRST, INITIAL)			
DATE	TIME ☐AM☐PM	SEX☒M ☐F	RACE/ETHNIC ☐B ☐W ☐H ☐ O

Circle appropriate response. (YES or NO). YES REQUIRES SPECIFIC INFORMATION FOLLOWING EACH QUESTION.

PART I VISUAL OBSERVATION		YES	NO
1.	Is the resident unconscious? Are there signs of breathing difficulties?	☐	☐
2.	Does the resident have obvious pain or bleeding or other symptoms suggesting a need for emergency care?	☐	☐
3.	Are there visible signs of trauma or illness requiring immediate emergency or doctor's care?	☐	☐
4.	Is there obvious fever, swollen glands, jaundice, or other evidence of infection that might spread through the facility?	☐	☐
5.	Is there a significant rash or other skin abnormalities on the resident's body such as trauma markings, bruises, lesions, recent tattoos, or needle marks?	☐	☐
6.	Are signs of body vermin/infestation noted?	☐	☐
7.	Does the resident appear to be under the influence of barbiturates, heroin, cocaine, alcohol, or other drugs?	☐	☐
8.	Are there visible signs of alcohol or drug withdrawal symptoms such as tremors or sweating?	☐	☐
9.	Does the resident's behavior suggest the risk of suicide?	☐	☐
10.	Does the resident's behavior suggest the risk of assault to staff or other residents?	☐	☐
11.	Does the resident's appearance or conduct suggest risk to self, staff, or other residents?	☐	☐
12.	Does the resident show signs of recent weight loss or fatigue?	☐	☐

PART IIHEALTH STAFF-RESIDENT QUESTIONNAIRE				
1.	(a)	Have you ever been told you have ☐diabetes, ☐heart disease, ☐arthritis, ☐AIDS, ☐asthma, ☐ulcers, ☐high blood pressure, ☐hepatitis, ☐TB, ☐seizure activity, ☐ infectious disease, or ☐psychiatric disorder? (Check if yes.)	☐	☐
	(b)	Do you take any medication?	☐	☐
2.	(a)	Are you presently on a diet ordered by a doctor?	☐	☐
	(b)	What is the diet?		
3.		Are you allergic to any medication or other substance, including food items? (Describe reaction.)	☐	☐
4.	(a)	Have you been hospitalized within the last 6 months or seen for any medical condition?	☐	☐
	(b)	Where? When? Why?		

5.	(a)	Have you ever been a patient in a mental institution or been in a “detox” program?	☐	☐
	(b)	Where? When? Why?		
	(c)	Have you ever thought about or tried to kill yourself?	☐	☐
	(d)	When? How?		
	(e)	Are you thinking of killing yourself now? If yes, Place resident on suicide watch.	☐	☐
	(f)	Do you have a plan?	☐	☐
6.		Are you having headaches, numbness in any part of your body, or changes in your vision or memory?	☐	☐
7.		Have you fainted or had a head injury within the last 6 months?	☐	☐
8.	(a)	Do you have a cough?	☐	☐
	(b)	Do you bring up sputum, phlegm, or blood?	☐	☐
9.		Do your teeth or gums hurt?	☐	☐
10.	(a)	Are you using alcohol? Daily intake? Last drink?	☐	☐
	(b)	Are you using heroin, methadone, “street drugs,” or other substances?	☐	☐
		Amount? Last use? Mode/Route?		
	(c)	Are you or have you been an intravenous or injection drug user?	☐	☐
	(d)	Have you shared needles or drug paraphernalia?	☐	☐
11.	(a)	Have you ever had a sexually transmitted disease or abnormal discharge?	☐	☐
	(b)	How treated? When?		
12.	(a)	Have you had unsafe sex with someone you know has the AIDS virus?	☐	☐
	(b)	Have you had multiple sexual partners?	☐	☐
	(c)	Have you had sex with someone of your own sex?	☐	☐
	(d)	Has anyone ever forced sex on you?	☐	☐
		Has it been reported? Yes ☐ No ☐		
		If the answer is yes to “d”, and it has not been reported:		
		STOP AND DO THE FOLLOWING!!!!!		
		1. Call the CPS Hotline 1-800-800-5556		
		2. Write an incident report		
		3. Email Leadership		
	(e)	Would you like to be tested for a STD or HIV?	☐	☐
13.		Have you ever had a blood transfusion? When?	☐	☐
14.		Have you had a severe rash in the past 2 years?	☐	☐
15.		Have you ever had pneumonia? When?	☐	☐
16.		Have you had any sores, infections, or white patches in your mouth?	☐	☐
17.		Do you sweat excessively at night?	☐	☐
18.		Do you have any other medical problems?	☐	☐
19.	(a)	Have you ever been tested for HIV virus?	☐	☐
	(b)	Where? When? Results?	☐	☐
20.		Where do you go for medical care? _____		
21.		Will you sign a form so we can get your health record?	☐	☐
22.		Do you understand how to get medical, mental health, or dental services?	☐	☐
23.		Have you received AIDS information?	☐	☐
24.		**Refer to**: ☐MD/RN ☐Mental Health ☐ Dental ☐HIV Counselor ☐HIV contact person	(Check one)	

☐Urgent ☐Urgent

All 'yes' answers are to be explained on the below

I have received information describing health services at this facility and understand how to access health care.

_____ _____

RESIDENT SIGNATURE ***STAFF SIGNATURE/TITLE***

EXPLAIN YES ANSWERS HERE: _____

Medical History

TO BE COMPLETED BY REFERRING FACILITY

RESIDENT NAME				DOB	ROOM #
ADMISSION DATE	INSTITUTION YCC	PULSE	RESPIRATION	BLOOD PRESSURE	TEMPERATURE

HEIGHT	WEIGHT	SEX	RACE	PPD	TETANUS	PREVIOUS CORRECTIONAL TIME
		Male				

INSTRUCTION TO OFFENDER: Complete the following sections through Signature only.

Allergies (Describe Agent and Reaction, Food, Medication, Other) _____

Language Barriers/Learning Deficits: _____

Childhood Illnesses (Indicate age of occurrence)

Measles	Mumps	Chicken Pox	Rubella	Other

Family Disease History (Indicate age, illness, cause of death)

	AGE	ILLNESS	CAUSE OF DEATH		AGE	ILLNESS	CAUSE OF DEATH
Mother				Sisters			
Father				Brothers			

Medical Treatment (Hospitalizations and operations, Include psychiatric treatment)

HOSPITAL AND LOCATION	REASON/DIAGNOSIS	DATE ADMITTED

Other Information (Include Psychiatric and other medications)

CURRENT MEDICATIONS	

STREET DRUGS: Type, Amount, Frequency, Date of Last Use, and any problems that occurred after ceasing use	USE OF NEEDLES ☐Yes ☐No
ALCOHOL USE: Type, Amount, Frequency, Date of Last Use, and any problems that occurred after ceasing use	TOBACCO USE: Type and Amount

SEXUAL HISTORY ***WHITE FOLDER***

Homosexual Experience ☐ Y ☐ N Number of Partners in Last Year _____

Victim of Sexual Abuse ☐ Y ☐ N Last Sexual Contact Date _____

Bisexual Experience ☐ Y ☐ N Sexually Transmitted Diseases (List: and give dates)

Contraceptive Method _____ _____

INSTRUCTIONS: Answer all questions. If you have any of the conditions listed below, answer YES or NO by placing a check in ☐. If a family member has a condition listed, place a check in ☐.

YES	NO	FAMILY		
☐	☐	☐	1.	TB or lived with anyone who had TB
☐	☐	☐	2.	Coughed up blood/bleeding disorder
☐	☐	☐	3.	Hay fever, asthma, or difficulty breathing
☐	☐	☐	4.	Emphysema
☐	☐	☐	5.	Sinus problems
☐	☐	☐	6.	Chronic or frequent colds
☐	☐	☐	7.	Frequent nose bleeds
☐	☐	☐	8.	Chest pain
☐	☐	☐	9.	Heart murmur
☐	☐	☐	10.	Rheumatic fever
☐	☐	☐	11.	Low or high blood pressure
☐	☐	☐	12.	Stomach trouble or ulcer
☐	☐	☐	13.	Frequent indigestion
☐	☐	☐	14.	Hemorrhoids
☐	☐	☐	15.	Frequent constipation or diarrhea
☐	☐	☐	16.	Gall bladder problems
☐	☐	☐	17.	Hepatitis, jaundice, or liver problems
☐	☐	☐	18.	Kidney problems
☐	☐	☐	19.	Blood in urine
☐	☐	☐	20.	Difficulty urinating
☐	☐	☐	21.	Diabetes or sugar in urine
☐	☐	☐	22.	Thyroid problems
☐	☐	☐	23.	Skin disease
☐	☐	☐	24.	Hernia or rupture
☐	☐	☐	25.	Tumor, cysts, or cancer
☐	☐	☐	26.	Attempted suicide
☐	☐	☐	27.	Alcoholism or drug addictions
☐	☐	☐	28.	Depression
☐	☐	☐	29.	Birth defects or deformities
☐	☐	☐	30.	Male genital problems
☐	☐	☐	31.	Eye, ear, nose, or throat trouble
☐	☐	☐	32.	Vision loss or hearing loss

YES	NO	FAMILY		
☐	☐	☐	33.	Glasses or contact lenses
☐	☐	☐	34.	Prosthesis or other corrective device
☐	☐	☐	35.	Dentures/partials
☐	☐	☐	36.	Severe tooth or gum problems
☐	☐	☐	37.	Head injuries
☐	☐	☐	38.	Frequent or severe headaches
☐	☐	☐	39.	Loss of consciousness, dizziness, or fainting
☐	☐	☐	40.	Paralysis, numbness
☐	☐	☐	41.	Muscle, bone, joint, ease of movement
☐	☐	☐	42.	Recurrent back trouble
☐	☐	☐	43.	Recurrent fever/night sweats
☐	☐	☐	44.	Rapid weight loss
☐	☐	☐	45.	Constant fatigue
☐	☐	☐	46.	Diminished appetite
☐	☐	☐	47.	White spots in mouth
☐	☐	☐	48.	Swollen glands
☐	☐	☐	49.	Seizure disorder

Females Only

☐	☐	☐	50.	Lumps, pain, or discharge from breast
☐	☐	☐	51.	Female disorders
☐	☐	☐	52.	Change in menstrual pattern
☐	☐	☐	53.	Age of first period _____
☐	☐	☐	54.	Last menstrual period _____
☐	☐	☐	55.	Length of period _____ days
☐	☐	☐	56.	Last Pap smear _____
☐	☐	☐	57.	Pregnancy:

	YOURSELF	MOTHER
How many pregnancies		
Of these # live births		
# of interrupted pregnancies		

REMARKS (Explain all Yes answers checked above)

I certify that I have reviewed the foregoing information and had the opportunity to discuss it with the staff and that it is true and complete to the best of my knowledge.

RESIDENT SIGNATURE	*DATE SIGNED*

STAFF SIGNATURE	DATE COMPLETED	TIME ☐ AM ☐PM

Mental Health Survey

NAME: _____ LOCATION: _____
(Last) (First) (M.I.)

DOB: _____ RM #: _____ S.S. # _____

SEX: Male RACE: _____ DATE ARRESTED: _____ HOW MANY TIMES IN JAIL: 1

HISTORY:

Have you been hospitalized in a psychiatric unit? Yes ☐ No ☐

If so, where? (Give dates) _____

Why? _____

Have you received outpatient counseling/treatment for emotional/nervous problems?

Yes ☐ No ☐ Where? (Give dates) _____

Past medications: _____ Current medications: _____

Last dosage: _____ Where or who prescribed the medications? _____

Do you have any current emotional problems? Yes ☐ No ☐ If so, describe: _____

Do you use any of the following?

	What Type	How Much	How Often	For How Long
Alcohol				
Amphetamines				
Cocaine				
Heroin				
Other				

Have you ever been treated for drug/alcohol abuse? Yes ☐ No ☐

If so, where? _____ When? _____

Where were you living before you were arrested? _____

Who is your immediate family? _____

If you have children, with whom do they stay? _____

Education completed: _____ Were you in special classes? Yes ☐ No ☐

Employment: _____ Are you on SSI? _____ Reason: _____

Have you ever attempted suicide? Yes ☐ No ☐ How many times? _____

Last time you attempted suicide? _____

How did you try it each time? (Describe): _____

Are you thinking about suicide now? Yes ☐ No ☐ If so, how would you do it? _____

Are you a violent person? Yes ☐ No ☐ If so, describe: _____

Do other people think you are violent? Yes ☐ No ☐ If so, Why? _____

Have you ever been charged with a violent crime? Yes ☐ No ☐ If so, When? _____

Why? _____

Do you ever think about hurting or killing other people? Yes ☐ No ☐ Reason: _____

Do you read and write in English? Yes ☐ No ☐

Other important information: _____

SIGNATURE: _____

OFFICE USE ONLY

REFERRAL PSYCHIATRIST, MD _____ NEXT SICK CALL _____ GENERAL POPULATION _____

INTERVIEWED BY _____ (Examiner's Name)

Source: Adapted from Coastal Correctional Healthcare, Inc., Durham, North Carolina.

CONSENT TO TREATMENT

_____ _____

Name of Resident ***Date***

_____ _____

Resident Room ***Date of Birth***

I hereby give my consent to the Youth Care Center's medical provider, its employees, and agents to perform any diagnostic laboratory procedures, examinations, x-rays, oral or injected medication, or other procedures recommended by the physician.

I am aware the practice of medicine is not an exact science, and I acknowledge no guarantees have been made regarding the result of treatments or examinations performed by the Youth Care Center's medical provider.

I also authorize the transfer of medical records or copies of said records to any facility to which I am referred for treatment or to any other correctional facility to which I am transferred.

I understand I may withdraw this consent to any specific treatment by refusing the treatment or test.

I sign this willingly in full understanding of the above and release the Youth Care Center and its medical provider, its employees, and agents from any and all liability that may arise from this action.

_____ _____

Parent/Guardian Signature ***Date***

_____ _____

Resident Signature/Date ***Staff Signature/Date***