



**STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE**

Youth Transport Card

Original Facility Name: _____

Phone Number: _____

Youth Name (Last, First):				
Youth DJJ#:				
Youth Date of Birth:				
Youth currently on medications? If yes, see Medication Distribution Record for next dose due.	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Youth with chronic condition or Alert (including psychiatric conditions?) If yes, see Health Discharge/Transfer Summary Note:	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO

*Special Health Related or Instructions: _____

Name of Person Completing Form: _____

Signature: _____