

Office of Health Services

Electronic Medical Record

Health Services Mandatory Required Forms

PERMISSION LEVELS

MEDICAL

- Medical ARNP
- Medical RN
- Medical LPN
- Medical Clerk
- Regional Nursing Consultant

MENTAL HEALTH

- Clinical Staff MH
- Clinical Staff SA
- Clinical Staff MH/SA
- Licensed MH
- Licensed SA/Certified Prof.
- Licensed MH/SA
- Treatment Team Member

NOTES

- All fields with Red “*” are mandatory
- Text boxes have a minimum of 15 characters, maximum varies.
- Even if answer is NO, a narrative is required, even if it’s “Not Applicable”
- Most text boxes have spell check
- To enter an Electronic Signature, confirm name, username and enter JJIS password

Department of Juvenile Justice System Login




From JJIS System Login, enter User Name and password, select OHS EMR Module and click "Login"

JJIS information is confidential. Users are required by law to maintain this confidentiality and use the information only for Department of Juvenile Justice approved purposes.

Failure to follow these restrictions may result in civil or criminal penalties.

Additional information is available on the DJJ website at:

<http://www.djj.state.fl.us/partners/data-integrity-jjis/access-agreements-policies>

User Name: *
Password: *
System: * 
☐ Change Password?

JJIS Help Desk (850) 921-7832

- ...
- Alerts
- CCC
- Electronic Educational Exit Plan
- JJIS
- OHS EMR Module
- Prevention Web
- RSMS
- SVS



DEPARTMENT OF JUVENILE JUSTICE

Electronic Medical Records

[Logout](#)

Protection of Confidentiality and Security of Healthcare Information.

Access to the Electronic Medical Record and healthcare information is limited to authorized persons with a need to know, to the extent necessary, to perform their job duties. The individual authorized to access a youth's Electronic Medical Record and healthcare information must utilize the User ID, password and electronic signature assigned to him/her by the Department of Juvenile Justice (DJJ). The individual understands that when an authorized individual's User ID and password are used to gain access to the Electronic Medical Record, the User, time of access and healthcare record accessed will be recorded and tracked in the JJIS System, and is subject to audit by the Department.

The confidentiality of healthcare information in the Electronic Medical Record must be maintained as set forth in Federal and State laws, DJJ rules and policies concerning the confidentiality, privacy, security, use and disclosure of healthcare information. Specific State and Federal requirements regarding the protection of healthcare records, particularly substance abuse records, mental health records and HIV-related information which prohibits release or further disclosure of said information without written consent must be followed. The individual understands that any violation of State and Federal law, DJJ rules and policies regarding confidentiality of healthcare information may result in disciplinary action, termination of employment and/or legal action.

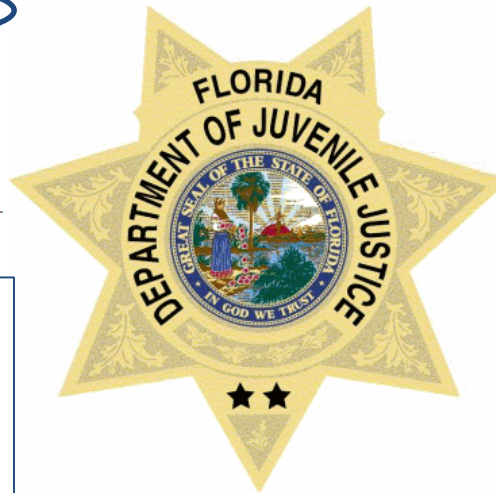
☐ I agree to the DJJ Office of Health Services Terms and Conditions

User Name:

Program Name:

Click [here](#) if you experience problems with the DJJ security certificate.

Select program/facility name from the drop down. Click on GO. Options are limited based on your permission profile



OUR VISION

The children and families of Florida will live in safe, nurturing communities that provide for their needs, recognize their strengths and support their success.

OUR MISSION

To increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services that strengthen families and turn around the lives of troubled youth.

Read the confidentiality statement and check the box to agree to the terms and conditions.



Active Youth and Links

Active Youth:

Youth's name/DJJ ID

[\(Facesheet\)](#) [\(PACT\)](#) [\(PACT MHSA Referral\)](#) [\(Alerts Module\)](#)

[Logout](#)

<<

Active Program:

Duval Regional Juvenile Detention Center ▼

Duval Regional Juvenile Detention Center

Facility Youth Listing: (76 total)

Facility Youth listed here

Active Program

Youth Listing



Menu Options – Varies with Permissions

OHS Management Reports

MH Referral / Sick Call / MH Review

Mental Health Forms

Medical Forms

Upload Library

Youth History

Pending Actions - 113

OUR VISION

Florida will live in safe, nurturing communities that provide for their needs, recognize their strengths and support their success.

OUR MISSION

Frequency through effective prevention, intervention and treatment services that strengthen families and turn around the lives of troubled youth.

- All youth with a current location of program will appear on tool bar located on left side
- Select youth or complete a youth search
- Once youth desired is selected they will appear as “Active Youth”
- **IMPORTANT** – Check your “Active Youth” listed to ensure correct (the youth you want to work with)
- To hide youth listing tool bar click on “<<” button
- To bring back youth listing tool bar click on “>>” button
- Click Medical Forms to access Core Profile forms

Mandatory/Required Forms

DEPARTMENT OF JUVENILE JUSTICE
Electronic Medical Records
MEDICAL FORMS

Home | Active Youth: Youth Name/DJJ ID | (Facesheet) | (PACT) | (PACT/MHSA Referral) | User Role: Medical RN | Logout

Youth Search <<

Active Program:
Alachua Regional Juvenile Detention Center
Alachua Regional Juvenile Detention Center
Facility Youth Listing: (39 total)

Facility Youth listed here

Mandatory/Required Forms

- ☐ Acknowledgment of Receipt of CPPN or Practitioner Form (PDF)
- ☐ Affidavit of Diligent Effort (PDF)
- ☐ Authority For Evaluation and Treatment
- ☐ Body Chart
- ☐ Clinical Psychotropic Progress Note (PDF)
- ☐ Clinical Psychotropic Progress Note Part B (PDF)
- ☐ Comprehensive Physical Assessment
- ☐ Controlled Medication Inventory Record (PDF)
- ☐ Custody of Individual Health Care Record (PDF)
- ☐ Individual Health Screening
- ☐ Summary – Transfer Note (PDF)
- ☐ Health Education Record
- ☐ Health Related History
- ☐ Immunization Tracking Record
- ☐ Individual Health Care Record Checklist and Internal Quality Control
- ☐ Infectious and Communicable Disease Form
- ☐ Limited Consent for Evaluation and Treatment (PDF)
- ☐ Medication And Treatment Record
- ☐ Medications
- ☐ Oral Health Assessment
- ☐ Parental Notification of Health Related Care: Vaccinations/Immunizations
- ☐ Notification of Health-Related Care: General
- ☐ Notification of Health-Related Care: Medications
- ☐ Personal and Health Related Information
- ☐ Problem List
- ☐ Sexually Transmitted Infections Screening Form
- ☐ Sick Call Index (PDF)
- ☐ **Sick Call Initiation**
- ☐ Sick Call Review
- ☐ Summary of Off-Site Care (PDF)

Recommended Forms

1. Select Youth from Facility Youth Listing or by Youth Search

2. Select Medical Forms

3. Select Mandatory/Required Forms

4. Select form to be completed

The Mandatory/Required Forms menu lists forms in alphabetical order.

- For each form to be completed:
1. Select Youth from Facility Youth Listing or by Youth Search
 2. Select Medical Forms
 3. Select Mandatory/Required Forms
 4. Select form to be completed

Uploading Signed Forms

Record Count: 0

[View Report](#) [Upload...](#)

Add the Medical Documents for youth.

Document Type:* ☒ Medical Forms ☐ Mental Health Forms

Document Name:* Acknowledgment of Receipt of CPPN or Practitioner Form

Document Date:*

Document Upload:* [Browse...](#)

You must view the document before you can save.

[View](#) [Save](#) [Cancel](#)

Add the Medical Documents for youth.

Document Type:* ☒ Medical Forms ☐ Mental Health Forms

Document Name:* Acknowledgment of Receipt of CPPN or Practitioner Form

Document Date:* 10/15/2015

Document Upload:* C:\Users\hutchinsr\Desktop\CPPN Form Oct 2015.doc [Browse...](#)

You must view the document before you can save.

[View](#) [Save](#) [Cancel](#)

Do you want to open or save **Q0028654176.doc** from **jjiswebqt164**?

[Open](#) [Save](#) [Cancel](#)

PDF forms should be printed, completed and signed as appropriate. Click View Report Link to print form.

Scan the signed document and save to PC.

Click Upload, enter the date of the document.

Click Browse to locate document on PC.

You must click View to confirm correct document is being uploaded.

Click open on the message bar. After viewing document, close and click Save.

File Uploaded Successfully

A message is displayed indicating successful upload.

Uploading Signed Forms

File Uploaded Successfully

[<< Back](#)

Name of Youth:
Date of Birth: DJJID#:

[Add New...](#)


	Document Name	Document Date	Category	Document Type	Modified By	Modified DateTime
Edit	Acknowledgment of Receipt of CPPN or Practitioner	10/15/2015	Medical Forms	Acknowledgment of Receipt of CPPN or Practitioner Form	RN Medical	10/15/2015 04:23 PM
Edit	Immunization Tracking Record	10/05/2015	Medical Forms	Immunization Tracking Record	RN Medical	10/14/2015 01:17 PM
Edit	Sexually Transmitted Infections Screening Form	10/12/2015	Medical Forms	Sexually Transmitted Infections Screening Form	RN Medical	10/12/2015 10:59 AM
Edit	Immunization Tracking Record	10/12/2015	Medical Forms	Immunization Tracking Record	RN Medical	10/12/2015 08:51 AM

When upload is complete, a message is displayed indicating successful upload.

File is listed in the table of uploaded documents.

A message is displayed indicating successful upload.

Acknowledgment of Receipt of CPPN or Practitioner Form (PDF)

 **FLORIDA DEPARTMENT OF JUVENILE JUSTICE**

**ACKNOWLEDGMENT OF RECEIPT OF
CLINICAL PSYCHOTROPIC PROGRESS NOTE OR PRACTITIONER FORM
(PARENTAL CONSENT FOR PSYCHOTROPIC MEDICATION)**

Youth's Name: DOB: DJJID:

Date Mailed to Parent: Facility Name:

Parent or Guardian Name
Mailing Address
City, State, Zip Code

Dear Mr./Mrs. :

Your child saw the practitioner on .

As part of your child's treatment, the practitioner has recommended that your child be prescribed the medication(s) listed on the attached form entitled Clinical Psychotropic Progress Note (CPPN) or the attached practitioner form that was completed on the day your child was seen.

This letter has been sent to you to:

☐ Confirm your oral consent to initiate this treatment, which you gave on .

☐ Obtain your written consent to begin this treatment, as we were unable to contact you by other means. It is important for you to contact us and return this form as soon as possible for treatment to begin. We cannot begin the recommended treatment without your consent.

If you have questions or wish to speak to staff about these medications, please call the following number and ask to speak to the contact person listed below:


Phone Number () Contact Person

PLEASE SIGN YOUR NAME AND DATE THE SIGNATURE ON THE LINES AT THE END OF THIS FORM TO ACKNOWLEDGE YOUR RECEIPT OF THE ATTACHED INFORMATION AND TO PROVIDE US WITH YOUR CONSENT FOR THE PSYCHOTROPIC MEDICATION LISTED ON THE ATTACHED CPPN OR PRACTITIONER FORM. AFTER SIGNING, PLEASE MAIL THIS LETTER BACK TO US AT:

Parent/Guardian Signature

Date Signed

(The attached Clinical Psychotropic Progress Note (CPPN) form or practitioner form that explains the medication is for you to keep. You do not need to send it back to us.)


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Complete form, mail to parent/guardian.

Returned form with signature should be uploaded to the EMR.

Affidavit of Diligent Effort (PDF)



FLORIDA DEPARTMENT OF JUVENILE JUSTICE AFFIDAVIT OF DILIGENT EFFORT

YOUTH NAME: Youth Name
DJJID# DJJ ID

_____, AN AUTHORIZED REPRESENTATIVE OF THE FLORIDA DEPARTMENT OF JUVENILE JUSTICE, certifies that the following information is true: That I have made a diligent search and inquiry for the parent(s)/guardian(s) of _____

Affiant further states that the whereabouts of the parent(s)/ guardian(s) of said youth are unknown as a result of this search. Refer to the checklist below and identify all action taken to locate parent(s)/ guardian(s):

- _____ Telephone listings in the last known locations of youth's residence
- _____ Telephone listings in the last known locations of parent(s)/ guardian(s) place of employment
- _____ Personal visit to youth's and families last known place of residence
- _____ Personal visit to locations of parent(s)/ guardian(s) place of employment
- _____ Telephone listings and/ or personal visit to place of residence of known relatives
- _____ Telephone listings and/ or personal visit to place of residence of known family friends
- _____ Law enforcement arrest and/ or criminal records check in the last known residential area of the youth's parent(s)/ guardian(s)
- _____ Utility companies, which include water, sewer, cable TV, and electric, in the last known area of the youth's parent(s)/ guardian(s)
- _____ Public assistance, which includes Medicaid, food stamps and temporary cash assistance, in the last known area of youth's parent(s)/ guardian(s)

I, _____ understand that I am swearing or affirming under oath to the truthfulness of the claims made in this affidavit and are filed in good faith and is true and correct to the best of my knowledge.

Dated: _____
Signature of Affiant
Printed Name: _____

Sworn to and subscribed before me
This _____ day of _____, 20 ____.

Signature Notary Public, State of Florida

Complete form,

Form with signature should be uploaded to the EMR.

Authority for Evaluation and Treatment

Core Profile

Mandatory/Required Forms

-  Acknowledgment of Receipt of CPPN or Practitioner Form (PDF)
-  Affidavit of Diligent Effort (PDF)
-  Authority For Evaluation and Treatment
-  Body Chart
-  Clinical Psychotropic Progress Note (PDF)
-  Clinical Psychotropic Progress Note Part B (PDF)
-  Comprehensive Physical Assessment
-  Controlled Medication Inventory Record (PDF)
-  Custody of Individual Health Care Record (PDF)
-  Facility Entry Physical Health Screening
-  Health Discharge Summary – Transfer Note (PDF)
-  Health Education Record
-  Health Related History
-  Immunization Tracking Record
-  Individual Health Care Record Checklist and Internal Quality Control
-  Infectious and Communicable Disease Form
-  Limited Consent for Evaluation and Treatment (PDF)
-  *Medication And Treatment Record*
-  *Medications*
-  Oral Health Assessment
-  Parental Notification of Health Related Care: Vaccinations/Immunizations
-  Parental Notification of Health-Related Care: General
-  Parental Notification of Health-Related Care: Medications
-  Personal and Health Related Information
-  Problem List
-  Sexually Transmitted Infections Screening Form
-  Sick Call Index (PDF)
-  ***Sick Call Initiation***
-  *Sick Call Review*
-  Summary of Off-Site Care (PDF)

Recommended Forms

This form included in Core Profile.
See the OHS – EMR – Medical Staff – Core Profile
power point for instructions.

Body Chart

Core Profile

Mandatory/Required Forms

-  Acknowledgment of Receipt of CPPN or Practitioner Form (PDF)
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-  Body Chart
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Recommended Forms

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power point for instructions.

Clinical Psychotropic Progress Note (PDF)

FLORIDA DEPARTMENT OF JUVENILE JUSTICE CLINICAL PSYCHOTROPIC PROGRESS NOTE	
NAME OF YOUTH: Youth Name/DOB/DJJ ID	
Prescribing Practitioner: _____	Allergies: _____
DJJ Facility (incl. phone number) _____	
Chief Complaint/Clinical Symptoms	
Mental Status Exam	
Diagnosis	
Axis I:	
Axis II:	
Axis III:	
Axis IV:	
GAF:	
Signature of Practitioner	
Printed Name	

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Page 1 of 2

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Revised October 2006

NAME OF YOUTH: Youth Name/DJJ ID
<small>This page requires completion only if an initial psychiatric diagnostic interview or psychiatric evaluation is conducted.</small>
Past Prescribing Practitioners
Past Mental Health Diagnoses
Past Medications & Responses
Past Therapy
Past Family Psychiatric History
Medical Problems/Surgeries
Other/Personal History
Drug/Alcohol Usage
Treatment Planning Recommendations:
Signature of Practitioner
Printed Name

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Page 2 of 2


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Revised October 2006

Complete form,
Form with signature
should be uploaded to
the EMR.

Clinical Psychotropic Progress Note Part B (PDF)

Complete form,

Form with signature should be uploaded to the EMR.



FLORIDA DEPARTMENT OF JUVENILE JUSTICE

CLINICAL PSYCHOTROPIC PROGRESS NOTE (Part B)

NAME OF YOUTH:	Youth Name/DJJ ID	DJJ Facility:			
*Psychotropic Medication Ordered	***Dosage & Frequency	Diagnosis/Target Symptoms	**Diagnosis/Clinical Justification	Common Side Effects	****Usual Dosage Range
1					
2					
3					
4					
5					

* Practitioner: Please write explicitly the medication regimen, even if it is unchanged from prior appointment
** Practitioner: Please provide brief rationale for each medication. If you are prescribing more than one psychotropic medication, please include a justification as to why more than one is required
*** Practitioner: If you wish to have medication increased on a specific date prior to youth's next appointment, please write as a separate order and include date of change
**** Practitioner: Only list usual dosage range if prescribed dosage exceeds the dosage typically prescribed for children.

Special Instructions to Facility Staff:

Frequency of Side Effects Monitoring:
Weekly or _____ Times per week

Tardive Dyskinesia Screening:
Monthly ☐ Yes ☐ No _____ Times per month

Schedule laboratory or other testing: _____
Date you wish to see the youth again: _____

Laboratory/Testing Reviewed:
☐ Yes ☐ No ☐ NA

If Abnormal, actions taken:


Treatment Plan/Medications/Risk & Benefits/Alternatives Explained to:
Youth: ☐ Yes ☐ No
Parent/Guardian: ☐ Yes ☐ No
Parent/Guardian Agrees to Treatment Plan:
☐ Yes ☐ No

Signature and printed name of witness to parental verbal consent

Date

Signature and printed name of prescribing Practitioner

Date



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Revised October 2006

Comprehensive Physical Assessment

Core Profile

Mandatory/Required Forms


- ☐ Acknowledgment of Receipt of CPPN or Practitioner Form (PDF)
- ☐ Affidavit of Diligent Effort (PDF)
- ☐ Authority For Evaluation and Treatment
- ☐ Body Chart
- ☐ Clinical Psychotropic Progress Note (PDF)
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- ☐ Controlled Medication Inventory Record (PDF)
- ☐ Custody of Individual Health Care Record (PDF)
- ☐ Facility Entry Physical Health Screening
- ☐ Health Discharge Summary – Transfer Note (PDF)
- ☐ Health Education Record
- ☐ Health Related History
- ☐ Immunization Tracking Record
- ☐ Individual Health Care Record Checklist and Internal Quality Control
- ☐ Infectious and Communicable Disease Form
- ☐ Limited Consent for Evaluation and Treatment (PDF)
- ☐ *Medication And Treatment Record*
- ☐ *Medications*
- ☐ Oral Health Assessment
- ☐ Parental Notification of Health Related Care: Vaccinations/Immunizations
- ☐ Parental Notification of Health-Related Care: General
- ☐ Parental Notification of Health-Related Care: Medications
- ☐ Personal and Health Related Information
- ☐ Problem List
- ☐ Sexually Transmitted Infections Screening Form
- ☐ Sick Call Index (PDF)
- ☐ ***Sick Call Initiation***
- ☐ *Sick Call Review*
- ☐ Summary of Off-Site Care (PDF)

Recommended Forms

This form included in Core Profile.
See the OHS – EMR – Medical Staff – Core Profile
power point for instructions.

[illegible]

Custody of Individual Health Care Record (PDF)



FLORIDA DEPARTMENT OF JUVENILE JUSTICE

CUSTODY OF INDIVIDUAL HEALTH CARE RECORD

NAME OF YOUTH:

Youth Name

 DOB:

DOB

 DJJID#:


DJJ ID

> Any movement of the Individual Health Care Record should be noted and dated here.

> It is advised that each facility maintain a copy of this form whenever custody changes.

> If relevant information arrives late, note here as well.

Date	Originating Facility <small>(Spell Out: Give Contact Name and Full Phone Number)</small>	Receiving Individual or Facility <small>(Spell Out: Give Contact Name and Full Phone Number)</small>



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Revised October 2006

Facility Entry Physical Health Screening

Core Profile


Mandatory/Required Forms

-  Acknowledgment of Receipt of CPPN or Practitioner Form (PDF)
-  Affidavit of Diligent Effort (PDF)
-  Authority For Evaluation and Treatment
-  Body Chart
-  Clinical Psychotropic Progress Note (PDF)
-  Clinical Psychotropic Progress Note Part B (PDF)
-  Comprehensive Physical Assessment
-  Controlled Medication Inventory Record (PDF)
-  Custody of Individual Health Care Record (PDF)
-  Facility Entry Physical Health Screening
-  Health Discharge Summary – Transfer Note (PDF)
-  Health Education Record
-  Health Related History
-  Immunization Tracking Record
-  Individual Health Care Record Checklist and Internal Quality Control
-  Infectious and Communicable Disease Form
-  Limited Consent for Evaluation and Treatment (PDF)
-  *Medication And Treatment Record*
-  *Medications*
-  Oral Health Assessment
-  Parental Notification of Health Related Care: Vaccinations/Immunizations
-  Parental Notification of Health-Related Care: General
-  Parental Notification of Health-Related Care: Medications
-  Personal and Health Related Information
-  Problem List
-  Sexually Transmitted Infections Screening Form
-  Sick Call Index (PDF)
-  ***Sick Call Initiation***
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-  Summary of Off-Site Care (PDF)

Recommended Forms

This form included in Core Profile.
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power point for instructions.

Health Discharge Summary - Transfer Note (PDF)



FLORIDA DEPARTMENT OF JUVENILE JUSTICE

HEALTH DISCHARGE SUMMARY TRANSFER NOTE

NAME OF YOUTH:

Youth Name

DATE:

DJJID#:

DJJ ID

DOB

DOB

Instructions: This form is to be used to provide health related information to parents/guardians providing after care for their children; to an after-care facility/re-entry program; and to Juvenile Probation Officers who require this information to supervise youth who are on community control. It can also be used for youth transferred between facilities. It is completed upon discharge from Residential Commitment Programs and Secure Detention Centers. A copy is to be filed in the Individual Health Care Record in the progress note section.

Facility/Program from which youth is discharged/transferred:

Contact Person:

Telephone Number:

E-mail Address:

Allergies: (List all Food, Medication, Animals, Plants, Insects, Other Allergens)

Medications youth is receiving at time of discharge. Include PRN & Emergency/Rescue medications. Copy exactly as the Medication Order is written:


(Include # of pills/inhalers, etc.)

Special Health Related Needs or Instructions (e.g. Diabetes, Asthma, Hearing or Vision deficit, Assistive device, Assistance with ADL):

Current Medical or Mental Health Alerts:

Pending Appointments: Include address & telephone number

Date	Provider (Name and Phone Number)	Purpose



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Revised October 2006

Health Education Record

Core Profile

Mandatory/Required Forms

-  Acknowledgment of Receipt of CPPN or Practitioner Form (PDF)
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-  *Sick Call Review*
-  Summary of Off-Site Care (PDF)

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Health Related History

Core Profile

Mandatory/Required Forms

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-  ***Sick Call Initiation***
-  *Sick Call Review*
-  Summary of Off-Site Care (PDF)

Recommended Forms

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power point for instructions.

Immunization Tracking Record

Core Profile

Mandatory/Required Forms

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-  Clinical Psychotropic Progress Note Part B (PDF)
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-  Summary of Off-Site Care (PDF)

Recommended Forms

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power point for instructions.

Individual Health Care Record Checklist and Internal Quality Control

Core Profile

Mandatory/Required Forms

- ☐ Acknowledgment of Receipt of CPPN or Practitioner Form (PDF)
- ☐ Affidavit of Diligent Effort (PDF)
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- ☐ Health Related History
- ☐ Immunization Tracking Record
- ☐ Individual Health Care Record Checklist and Internal Quality Control
- ☐ Infectious and Communicable Disease Form
- ☐ Limited Consent for Evaluation and Treatment (PDF)
- ☐ *Medication And Treatment Record*
- ☐ *Medications*
- ☐ Oral Health Assessment
- ☐ Parental Notification of Health Related Care: Vaccinations/Immunizations
- ☐ Parental Notification of Health-Related Care: General
- ☐ Parental Notification of Health-Related Care: Medications
- ☐ Personal and Health Related Information
- ☐ Problem List
- ☐ Sexually Transmitted Infections Screening Form
- ☐ Sick Call Index (PDF)
- ☐ ***Sick Call Initiation***
- ☐ *Sick Call Review*
- ☐ Summary of Off-Site Care (PDF)

Recommended Forms

This form included in Core Profile.
See the OHS – EMR – Medical Staff – Core Profile
power point for instructions.

Infectious and Communicable Disease Form

Core Profile




Mandatory/Required Forms

- ☐ Acknowledgment of Receipt of CPPN or Practitioner Form (PDF)
- ☐ Affidavit of Diligent Effort (PDF)
- ☐ Authority For Evaluation and Treatment
- ☐ Body Chart
- ☐ Clinical Psychotropic Progress Note (PDF)
- ☐ Clinical Psychotropic Progress Note Part B (PDF)
- ☐ Comprehensive Physical Assessment
- ☐ Controlled Medication Inventory Record (PDF)
- ☐ Custody of Individual Health Care Record (PDF)
- ☐ Facility Entry Physical Health Screening
- ☐ Health Discharge Summary – Transfer Note (PDF)
- ☐ Health Education Record
- ☐ Health Related History
- ☐ Immunization Tracking Record
- ☐ Individual Health Care Record Checklist and Internal Quality Control
- ☐ Infectious and Communicable Disease Form
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- ☐ Parental Notification of Health-Related Care: Medications
- ☐ Personal and Health Related Information
- ☐ Problem List
- ☐ Sexually Transmitted Infections Screening Form
- ☐ Sick Call Index (PDF)
- ☐ ***Sick Call Initiation***
- ☐ *Sick Call Review*
- ☐ Summary of Off-Site Care (PDF)

Recommended Forms

This form included in Core Profile.
See the OHS – EMR – Medical Staff – Core Profile
power point for instructions.

Limited Consent for Evaluation and Treatment (PDF)

 FLORIDA DEPARTMENT OF JUVENILE JUSTICE LIMITED CONSENT FOR EVALUATION AND TREATMENT		Youth Name/DJJ ID
NAME OF YOUTH: Youth Name		
DJJID#: DJJ ID	MEDICAID #: _____ <small>(AS APPLICABLE)</small>	
THIS AUTHORITY IS LIMITED AS FOLLOWS:		
<u>QUALITY OF TREATMENT</u>		
<p>A) The child will be examined and medically treated only by persons who are properly qualified to perform such examinations and provide such treatment with exception to defined circumstances as stated herein.</p> <p>B) Any treatment authorized by the Department must be recommended by a person licensed in Florida and permitted under Florida law to make such a recommendation.</p> <p>C) Any treatment authorized by the Department must be recommended in accordance with the medical or mental health standards in the community where the treatment will take place.</p>		
<u>WHAT THIS CONSENT COVERS</u>		
<p>1. Physical examinations conducted in accordance with the usual accepted medical standards of the community. These examinations may include:</p> <ul style="list-style-type: none">a) Determining whether the child is currently suffering from any illness or disease or has any problems that require medical treatment while the Department has the youth in its physical custody.b) Obtaining a complete medical and mental health history from the child, including information about past illnesses, hospitalizations, etc.c) Testing for drug and/or alcohol abuse.d) Blood, urine, tuberculosis and other laboratory tests that may be done as part of a complete physical examination.e) Examining the child for any dental problems, and providing emergency dental care and treatment.f) Testing the child's vision and hearing.g) Gynecological examination. <p>2. Give permissions to a licensed health care provider to give the child additional tests that he or she thinks are necessary as a result of a physical examination.</p> <p>3. Obtain necessary medical and clinical treatment for any illness or disease that the child has now or develops while he/she is in the Department's facility.</p> <p>4. Regarding mental health or emotional illnesses that the child now has or develops while in the custody of a Department facility, the Department may arrange for, make available and facilitate mental health assessments and treatment with licensed mental health care providers or mental health facilities, including diagnostic assessment, psychological testing, and individual, group, and family therapy and/or counseling, except as otherwise provided in this section. This section shall not be read as authorizing my consent to the commitment of my child to a residential facility licensed under Chapter 393, Florida Statutes (Developmental Disabilities) or Chapter 394, Florida Statutes (mental health), but is acknowledging commitment under Chapter 983, Florida Statutes. If hospitalization in a mental health facility is recommended, I will be notified in advance, and will have the opportunity to object if I wish to.</p> <p>5. Obtain prescription medications that are currently prescribed, excluding psychotropic medications, for the child.</p> <p>6. Regarding vaccinations/immunizations, the Department may provide the standard vaccinations, if the child has not had them and/or if they are not up to date and/or if they are required to attend school in Florida, such as for tetanus, measles, polio, and Hepatitis B and after review of the necessary information about the immunization(s).</p> <p>7. I authorize licensed health care and non-health care staff members to provide antipyretics, non-steroidal anti-inflammatory medications (excluding Aspirin), anti-indigestion medications, antacids, Triple Antibiotic Ointment and antihistamines for the purpose of allergic reactions only. All of these medications shall be administered in accordance with the manufacturer's recommended dosage, to the child for minor physical complaints. I understand that the child will receive a medical evaluation for minor complaints that are unrelieved by these over-the-counter medications. I understand that all other over-the-counter medications will be provided pursuant to a Physician's approval.</p>		
<div style="text-align: center;"> <small>HS 057 Page 1 of 3</small></div> <div style="text-align: right;"><small>12/13</small></div>		
<div style="text-align: center;"> <small>HS 057 Page 2 of 3</small></div> <div style="text-align: right;"><small>12/13</small></div>		

8. *ACCESS TO RECORDS. The Department shall have access to all records of whatever nature concerning the mental and physical health of the child. I direct that any and all health care providers, whether involved in mental or physical health care, shall provide all records concerning the child to the Department at the request of the Department and/or its authorized agents. These records also include any evaluations, assessments, and/or treatments of the child provided in the future, while the child is in the custody of the Department. It is my intent that this document acts as the consent and release of these records to the Department and/or its authorized agents.*

WHAT THIS CONSENT DOES NOT COVER

1. I understand this Consent applies only when the child is staying 24 hours a day at a Department detention facility.

2. The Department has the right to choose the health care provider as long as the person is properly qualified in Florida. However, in certain instances, the Department may be able to utilize the child's usual provider, particularly if this is convenient for the facility, and the provider agrees to do so.

3. This signed consent does not provide authorization for substance abuse treatment. The child must provide his or her consent to this treatment.

4. This signed consent does not authorize the provision of psychotropic medications.

ACKNOWLEDGEMENTS

I am consenting to necessary vaccinations. I have received the following Vaccine Information Sheet (s): _____ (list here)

DATED THIS _____ DAY OF _____, 20 _____

FOR YOUTH NOT IN THE DEPENDENCY SYSTEM:
THE PARENT OR GUARDIAN COULD NOT BE CONTACTED AFTER A DILIGENT SEARCH. THE JPO SHALL ATTACH AN AFFIDAVIT OF DILIGENT EFFORT (HS 056), AND THE FACILITY SUPERINTENDENT OR ASSISTANT MAY SIGN. A FULL AUTHORITY FOR EVALUATION AND TREATMENT (HS 002) SHALL BE OBTAINED AS SOON AS POSSIBLE, WHICH SHALL SUPERSEDE THIS LIMITED CONSENT.

DETENTION FACILITY SUPERINTENDENT (SIGNATURE)	WITNESSED BY: DJJ REPRESENTATIVE (SIGNATURE)
DETENTION FACILITY SUPERINTENDENT (PRINTED)	DJJ REPRESENTATIVE (PRINTED)

Limited Consent for Evaluation and Treatment (PDF)

Youth Name/DJJ ID

FOR YOUTH IN THE DEPENDENCY SYSTEM WHO REMAIN IN THE HOME OF PARENT OR GUARDIAN:
WHERE THE PARENT OR GUARDIAN COULD NOT BE CONTACTED AFTER A DILIGENT SEARCH, THE JPO SHALL ATTACH AN AFFIDAVIT OF DILIGENT EFFORT (HS 050), AND THE FACILITY SUPERINTENDENT OR ASSISTANT MAY SIGN.

PARENT OR GUARDIAN (SIGNATURE) WITNESSED BY: DJJ REPRESENTATIVE (SIGNATURE)

PARENT OR GUARDIAN (PRINTED) DJJ REPRESENTATIVE (PRINTED)

OR

DETENTION FACILITY SUPERINTENDENT (SIGNATURE)

DETENTION FACILITY SUPERINTENDENT (PRINTED)

FOR YOUTH IN THE DEPENDENCY SYSTEM WHO ARE IN OUT-OF-HOME CARE:
THE JPO SHALL CONTACT THE DEPARTMENT OF CHILDREN AND FAMILIES OR ITS CONTRACTED SERVICE PROVIDER TO OBTAIN LIMITED CONSENT FROM THE PARENT, THE DEPARTMENT OF CHILDREN AND FAMILIES, OR THE OUT-OF-HOME CAREGIVER, AS REQUIRED BY THE COURT'S ORDER OF PLACEMENT.

PARENT OR GUARDIAN (SIGNATURE) WITNESSED BY: DCF REPRESENTATIVE (SIGNATURE)

PARENT OR GUARDIAN (PRINTED) DCF REPRESENTATIVE (PRINTED)

OR

DCF CASE MGR. / CONTRACTED PROVIDER (SIGNATURE)

DCF CASE MGR. / CONTRACTED PROVIDER (PRINTED)

OR

OUT-OF-HOME CAREGIVER (SIGNATURE)

OUT-OF-HOME CAREGIVER (PRINTED)

FOR YOUTH IN THE DEPENDENCY SYSTEM WITH A TERMINATION OF PARENTAL RIGHTS:

DCF CASE MGR. / CONTRACTED PROVIDER (SIGNATURE) WITNESSED BY: DJJ REPRESENTATIVE (SIGNATURE)

DCF CASE MGR. / CONTRACTED PROVIDER (PRINTED) DJJ REPRESENTATIVE (PRINTED)

This form should be uploaded after completion.

Medication And Treatment Record

Youth's Name: **Youth Name** DOB: **DOB** Sex: Male Race: Black DJJID: **DJJ ID**

Youth Medication And Treatment Record. Month / Year: **October** / **2015** **MAR Report** **PRN Medications Report** **<< Back**

Allergies, Medical and Other Info. **Youth Medications** **MAR Filter**

Facility Name: * **Select Facility**

Physician: (Max:25 characters)

Medical Grade: *

Diagnosis : * **94 characters remaining...** **Check Spelling**

Med / MH Alerts: * **99 characters remaining...** **Check Spelling**

List Allergies / Common Side Effects / Precautions (please enter maximum 4 lines of data.)

240 characters remaining... **Check Spelling**

Update **Cancel**

***** Ensure the youth you want is the active youth !!**

There are 3 Tabs for a MAR:

- Allergies, Medical and Other Info [must be completed first]
- Youth Medications
- MAR Filter - allows to filter what medications appear on report

Start at top and complete all fields and then select "Update"

Medication And Treatment Record

Youth Medication And Treatment Record.

Month / Year September / 2014

MAR Report

PRN Medications Report

<< Back

Allergies, Medical and Other Info.

Youth Medications

MAR Filter

Select Add Youth
Medication >

Youth Medication List: Open/Active

Add Youth Medication

	Medication Name	Dosage	Frequency	Method of Delivery	Start Date	End Date	Created By	Created Date	Modified By	Modified Date
--	-----------------	--------	-----------	--------------------	------------	----------	------------	--------------	-------------	---------------

No records found.

Youth Medication And Treatment Record.

Month / Year September / 2014

MAR Report

PRN Medications Report

<< Back

Allergies, Medical and Other Info.

Youth Medications

MAR Filter

Add Youth Medication Information.

Medication Name: * Amoxicillin (Amoxil)

Usage: * ☐ Psychotropic ☐ Other

Dosage: * 20 MG (Max: 20 characters)

Frequency: * 1X a day in evening (Max: 50 characters)

Method of Delivery: * Oral (by mouth)

☐ PRN (OR) Time1: Time2: Time3: Time4: 06:30 PM

Side Effects
Monitoring:

upset stomach, N/V

Start Date: * 9/29/2014

End Date: * 10/6/2014

Save

Cancel

Youth Medication List: Open/Active

Add Youth Medication

	Medication Name	Dosage	Frequency	Method of Delivery	Start Date	End Date	Created By	Created Date	Modified By	Modified Date
--	-----------------	--------	-----------	--------------------	------------	----------	------------	--------------	-------------	---------------

No records found.

All listed medication for youth will be displayed if entered.

There is also a sort field drop down box to display open/closed medications

Start at top and select Medication from drop down. Select Usage, Input Dosage, Frequency, and Method of Delivery and then select PRN or input times.

Side effects entered under the medication tab will automatically populate in the Side Effects Monitoring box.

Enter Start and End Dates Then "Save"

Select Medication from drop down.

Note: Only medications entered in Medication module will appear in drop down

Medication And Treatment Record

>> Please minimize number of upper case letters to retain report layout.

Youth medication information saved successfully. ←

Youth's Name: DOB: Sex: [Male](#) Race: [Black](#) DJJID:

Youth Medication And Treatment Record. Month / Year / [MAR Report](#) [PRN Medications Report](#) << Back

Allergies, Medical and Other Info. [Youth Medications](#) [MAR Filter](#)

Youth Medication List: [Add Youth Medication](#)

	Medication Name	Dosage	Frequency	Method of Delivery	Start Date	End Date	Created By	Created Date	Modified By	Modified Date
Edit	Benadryl cream	as needed to cover	2X Daily	Topical (to skin)	09/29/2014	10/06/2014	Rosellyn Hutchins	09/29/2014 11:50 AM		
Edit	Amoxicillin (Amoxil)	20 MG	1X a day in evening	Oral (by mouth)	09/29/2014	10/06/2014	Rosellyn Hutchins	09/29/2014 11:27 AM		

Once saved the user will see message:

Youth medication information saved successfully.

The medication will appear in table and can be edited

Medication And Treatment Record

Youth Medication And Treatment Record.

Month / Year September / 2014

MAR Report

PRN Medications Report

<< Back

Allergies, Medical and Other Info.

Youth Medications

MAR Filter

Select medicines you want to print on MAR

Add Youth Medication

	Medication Name	Dosage	Frequency	Method of Delivery	Start Date	End Date	Created By	Created Date	Modified By	Modified Date
<input checked="" type="checkbox"/>	Amoxicillin (Amoxil)	20 MG	1X a day in evening	Oral (by mouth)	09/29/2014	10/06/2014	Rosellyn Hutchins	09/29/2014 11:27 AM		

Using the filter tab will allow you to only print selected medicines to a MAR. Medicines not selected will not print to the MAR. You must assure that the records for the youth allow the youth to get all ordered medications.

Print MAR with selected medicines

Cancel

Print Confirmation

You have selected a filtered MAR. Below are the medicines that will and will not print on the filtered MAR. Select continue to print and cancel to return to the MAR filter tab.

Will Print	Will not print
Amoxicillin (Amoxil)	

Continue to Print

Cancel

MAR Filter – The MAR filter tab allows a user to select medications to print to the MAR report.

Select the medications for the report by using the check box.

Select “Print MAR with selected medications”

A confirmation will appear with medications selected and any not selected to print to MAR.

“Will not print” box shows any other medications not included in MAR report.

Continue to print will populate the MAR with ONLY the medications selected.

Medication And Treatment Record

Youth Medication And Treatment Record.

Month / Year /

MAR Report

PRN Medications Report

<< Back

Select month and year to be printed.


Select MAR Report. Open PDF.

This form should be uploaded after completion.

Youth Photo

Month/Year: **October / 2015**

Physician: **Bala Krishnan MD**



FLORIDA DEPARTMENT OF JUVENILE JUSTICE
MEDICATION ADMINISTRATION RECORD/
MEDICATION AND TREATMENT RECORD (MAR)

List Allergies/Common Side Effects/Precautions:
nkda / nka

Codes: 0 = Not Administered
X = Not to be Given
R = Refusal
H = Medication Holiday
HV = Home Visit
Ø = No Side Effects
SE = Side Effects (See Nurses Note)
NLYI Nurse/Staff Initials/
Youth Initials

Medication/TX	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	
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Start _____ Stop _____		/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	
Transcriber Init _____		/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	
Side Effects Monitoring																																

Medication/TX	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	
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Start _____ Stop _____		/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	
Transcriber Init _____		/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	
Side Effects Monitoring																																

Youth Name **Youth Name**

DJJID # **DJJ ID** DOB **DOB**


Facility **Alachua Regional Juvenile Detention Center**

Medical Grade **1**

Diagnosis **R/O TB**

Med/MH Alerts **0**

Signature Nurse/Staff	Initials	Print Name	Signature Nurse/Staff	Initials	Print Name

Youth Signature and Initials

HS 019

DJJ/OHSFRM 019 06/2014 63M-2

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Medication And Treatment Record

Youth Medication And Treatment Record. Month / Year / **MAR Report** **PRN Medications Report** << Back

Youth Medication And Treatment Record. Month / Year / **MAR Report** **PRN Medications Report** << Back

Youth Medication And Treatment Record. Month / Year / **MAR Report** **PRN Medications Report** << Back

Youth Medication And Treatment Record. Month / Year / **MAR Report** **PRN Medications Report** << Back

Youth Medication And Treatment Record. Month / Year / **MAR Report** **PRN Medications Report** << Back

[illegible]

Select month and year to be printed.

Select PRN Medications
Report. Open PDF.

This form should be
uploaded after completion.

Medications

To be used when adding any medications that may not already be entered in database.

When you complete the MARs, the medications and side effects will appear.

Conduct a comprehensive search for the medication before selecting “New” to add it to the list.

Note: Medications are not youth specific

Medications

>> Please minimize number of upper case letters to retain report layout.

☐ Psychotropic Medication

Medication Name: *

Medication Usage: *

7500 characters remaining...

Check Spelling

Medication Side Effects: *

7500 characters remaining...

Check Spelling

* ☒ Active ☐ Inactive

[Rx List](#)

[PDR Health](#)

New

Save

Cancel

Medication Search (minimum 2 characters):

Find

	Medication Name	Last Updated By	Last Updated On	Is Active
Select	A&D Ointment	Pati Messick	08/01/2014 07:09 PM	Yes
Select	Abacavir Sulfate (Ziagen)	MedicalRN OHS	07/12/2013 08:31 PM	Yes
Select	Abacavir Sulfate/Lamivudine (Epzicom)	OHSFacSup OHS	07/12/2013 09:22 PM	Yes
Select	Abilify	Lindsay Peabody	08/02/2014 04:02 PM	Yes
Select	Abreva	Nicholene Onfroy	02/23/2014 05:29 PM	Yes
Select	Ace Wrap	Susan Chenowith	06/27/2014 07:53 PM	Yes

To conduct a comprehensive search for the medication, enter a minimum of two characters, and click “Find” for results

If no results are returned, click “New” to add the medication to the list.

Medications

☐ Psychotropic Medication

Medication Name: *

Medication Usage: *

Medication Side Effects: *

7500 characters remaining...

Check Spelling

Check Spelling

* ☒ Active ☐ Inactive

[Rx List](#) [PDR Health](#)

New Save Cancel

Complete all fields starting at top
Select Medication as "Active" for use in OHS.
"Inactive" removes medication from use in OHS.

Medication Search (minimum 2 characters): Find

	Medication Name	Last Updated By	Last Updated On	Is Active
Select	A&D Ointment	Pati Messick	08/01/2014 07:09 PM	Yes
Select	Abacavir Sulfate (Ziagen)	MedicalRN OHS	07/12/2013 08:31 PM	Yes
Select	Abacavir Sulfate/Lamivudine (Epzicom)	OHSFacSup OHS	07/12/2013 09:22 PM	Yes
Select	Abilify	Lindsay Peabody	08/02/2014 04:02 PM	Yes
Select	Abreva	Nicholene Onfroy	02/23/2014 05:29 PM	Yes
Select	Ace Wrap	Susan Chenowith	06/27/2014 07:53 PM	Yes

Select Save to Add Medication

Medications

>> Please minimize number of upper case letters to retain report layout.

☐ Psychotropic Medication

Medication Name: *

Medication Usage: *

7500 characters remaining...

Ch

Medication Side Effects: *

7500 characters remaining...

Check Spelling

* ☒ Active ☐ Inactive

[Rx List](#)


[PDR Health](#)

New

Save

Cancel

These links should be used confirm medication name and side effects

**RxList**
The Internet Drug Index

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July 3, 2013

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No Exact Match Found

Your search request did not match any articles on RxList.com. We may still have what you are searching for. We suggest you search again using different keywords or if you're not sure of the spelling, type the first few letters, followed by an asterisk(*).

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- Pill Identifier Tool - identify drugs and medications by imprint, color, or shape. Includes drug pictures.
- Picture Slideshows - interactive medical slideshow on important medical topics.
- Image Gallery - learn about skin disorder, medical anatomy, tumors and more through images and illustrations.
- Latest Drug News - WebMD & FDA Updates and news releases on prescription medications and drug manufacturing/distribution.
- Diseases, Condition and Tests - The RxList disease and condition listing contains explanations of many diseases, conditions, medical procedures and tests.
- Drug Medical Dictionary - definitions and explanations of many medical terms including prescription medication abbreviations.

Top 10 Most Popular Drugs on RxList

- Neurontin (gabapentin)
- Celebra (celecoxib)
- Xanax (alprazolam)
- Klonopin (clonazepam)
- Cipro (ciprofloxacin hydrochloride)
- Percoet (oxycodone and acetaminophen)
- Vicodin (hydrocodone bitartrate and acetaminophen)
- Ultram (tramadol hydrochloride)

Psoriasis

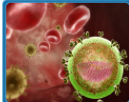
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Oral Health Assessment

Core Profile

Mandatory/Required Forms

-  Acknowledgment of Receipt of CPPN or Practitioner Form (PDF)
-  Affidavit of Diligent Effort (PDF)
-  Authority For Evaluation and Treatment
-  Body Chart
-  Clinical Psychotropic Progress Note (PDF)
-  Clinical Psychotropic Progress Note Part B (PDF)
-  Comprehensive Physical Assessment
-  Controlled Medication Inventory Record (PDF)
-  Custody of Individual Health Care Record (PDF)
-  Facility Entry Physical Health Screening
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-  Sick Call Index (PDF)
-  ***Sick Call Initiation***
-  *Sick Call Review*
-  Summary of Off-Site Care (PDF)

Recommended Forms

This form included in Core Profile.
See the OHS – EMR – Medical Staff – Core Profile
power point for instructions.

Parental Notification of Health Related Care: Vaccinations/Immunizations

Youth's Name:	<input type="text" value="Youth Name"/>	DOB:	<input type="text" value="DOB"/>	Sex:	Male	Race:	Black	DJJID:	<input type="text" value="DJJ ID"/>
---------------	---	------	----------------------------------	------	----------------------	-------	-----------------------	--------	-------------------------------------

DATE: _____

PARENT/GUARDIAN:* ▼

PARENT/GUARDIAN ADDRESS:


DJJ FACILITY:* ▼

DJJ FACILITY ADDRESS: _____

Dear _____

Our records indicate that you are the parent or guardian who has authority over health care for the above named youth. The purpose of this form is to notify you that the following vaccination(s) has/have been ordered for your child. We have included a Vaccine Information Sheet known as a "VIS" that explains the vaccination(s).

Name of Vaccination/VIS:* ▼

Publication Date of VIS:*  ☐ Have attached VIS form

If you have any further questions about this vaccination, please notify the DJJ facility at the phone number indicated.

Phone Number: () - Ext

Person to Contact:

Name of person at facility who completed this form _____

Staff: Prior to mailing, list the name of the VIS included with this notification, and the date of the publication of the VIS (located in the lower right hand corner of the VIS).

*** Copy of Notification to be filed in Individual Health Care Record.*

No File Uploads for the Current Youth

Select form from mandatory forms listing.
Complete information from the top down.
Click Elec. Sign Save>>.

This document must be mailed to
Parent/Guardian for signature.

Parental Notification of Health Related Care: Vaccinations/Immunizations



Form: Parental Notification of Health Related Care: Vaccinations/Immunizations for

Youth Name/DJJ ID

Record Count: 2

New

Upload...


	Form	Ref#	Type	Program Name	Modified Date Time	Modified By	Status
Select			EMR Form	Alachua Regional Juvenile Detention Center	10/16/2015 02:30 PM	Medical, RN	Completed
Select			EMR Form	Alachua Regional Juvenile Detention Center	10/16/2015 02:28 PM	Medical, RN	Completed

Click the PDF icon for the Vaccinations/Immunizations form to be mailed for parent/guardian signature.


Open and print form.

Parental Notification of Health Related Care: Vaccinations/Immunizations

FLORIDA DEPARTMENT OF JUVENILE JUSTICE PARENTAL NOTIFICATION OF HEALTH-RELATED CARE: VACCINATION/IMMUNIZATION	
NAME OF YOUTH: <u>Youth Name</u>	DATE OF BIRTH: <u>DOB</u>
FACILITY NAME: <u>Alachua Regional Juvenile Detention Center</u>	DJJID#: <u>DJJ ID</u> Date: <u>10/16/2015</u>
PARENT/GUARDIAN NAME AND ADDRESS: <u>Parent/Guardian</u> <u>Address</u>	
DJJ FACILITY NAME AND ADDRESS: <u>Alachua Regional Juvenile Detention Center</u> <u>3440 Northeast 39th Avenue Gainesville, FL 32609</u>	
Dear <u>Parent/Guardian</u> :	
Our records indicate that you are the parent or guardian who has authority over health care for the above named youth. The purpose of this form is to notify you that the following vaccination(s) has/have been ordered for your child. We have included a Vaccine Information Sheet known as a "VIS" that explains the vaccination(s).	
Name of Vaccination/VIS: <u>Varicella</u>	
Publication Date of VIS: <u>09/29/2015</u>	
If you have any further questions about this vaccination, please notify the DJJ facility at the phone number indicated.	
Phone Number: <u>(850) 555-1212</u>	
Person to Contact: <u>Smith</u>	
In order for us to provide this vaccination, we need your written permission. Please sign your name and date your signature in the space provided and send this form back to us at the address listed above.	
<input type="checkbox"/> I consent <input type="checkbox"/> I do not consent	




DJJ/OHSFRM 022 06/2014 63M-2



HS 022
Page 1 of 2

Revised February 2010

Parent/Guardian Signature _____	Date Signed _____
Name of person at facility who completed this form <u>Medical RN, RN</u>	
<i>Staff: Prior to mailing, list the name of the VIS included with this notification, and the date of the publication of the VIS (located in the lower right hand corner of the VIS). ** Copy of Notification to be filed in Individual Health Care Record.</i>	



DJJ/OHSFRM 022 06/2014 63M-2

HS 022
Page 2 of 2

Revised February 2010

Parental Notification of Health Related Care: Vaccinations/Immunizations



Form: Parental Notification of Health Related Care: Vaccinations/Immunizations for

Youth Name/DJJ ID

Record Count: 2

New

Upload...

	Form	Ref#	Type	Program Name	Modified Date Time	Modified By	Status
Select			EMR Form	Alachua Regional Juvenile Detention Center	10/16/2015 02:30 PM	Medical, RN	Completed
Select			EMR Form	Alachua Regional Juvenile Detention Center	10/16/2015 02:28 PM	Medical, RN	Completed

DJJ FACILITY:*

Alachua Regional Juvenile Detention Center

DJJ FACILITY ADDRESS:

3440 Northeast 39th Avenue Gainesville, FL 32609

Dear

Parent/Guardian

Our records indicate that you are the parent or guardian who has authority over health care for the above named youth. The purpose of this form is to notify you that the following vaccination(s) has/have been ordered for your child. We have included a Vaccine Information Sheet known as a "VIS" that explains the vaccination(s).

Name of Vaccination/VIS:*

Varicella

Publication Date of VIS:*

09/29/2015



☒ Have attached VIS form

If you have any further questions about this vaccination, please notify the DJJ facility at the phone number indicated.

Phone Number: (

850

)

555

-

1212

Ext

Person to Contact:

Smith

Name of person at facility who completed this form Medical, RN, RN

Staff: Prior to mailing, list the name of the VIS included with this notification, and the date of the publication of the VIS (located in the lower right hand corner of the VIS).

*** Copy of Notification to be filed in Individual Health Care Record.*

Elec.Sign Save >>

Upload Document

No File Uploads for the Current Youth

When signed form is received from the Parent/Guardian, it must be uploaded to the EMR.

Click select for the Vaccinations/Immunizations form to be uploaded with parent/guardian signature.

Click Upload Document to upload signed document.

Parental Notification of Health Related Care: Vaccinations/Immunizations

File Uploaded Successfully

[<< Back](#)

Name of Youth:

Date of Birth: DJJID#:

[Add New...](#)

	Document Name	Document Date	Category	Document Type	Modified By	Modified DateTime
Edit	Parental Notification of Health Related Care: Vacc	10/16/2015	Medical Forms	Parental Notification of Health Related Care: Vaccinations/Immunizations	RN Medical	10/16/2015 03:11 PM
Edit	Acknowledgment of Receipt of CPPN or Practitioner	10/15/2015	Medical Forms	Acknowledgment of Receipt of CPPN or Practitioner Form	RN Medical	10/15/2015 04:23 PM
Edit	Immunization Tracking Record	10/05/2015	Medical Forms	Immunization Tracking Record	RN Medical	10/14/2015 01:17 PM
Edit	Sexually Transmitted Infections Screening Form	10/12/2015	Medical Forms	Sexually Transmitted Infections Screening Form	RN Medical	10/12/2015 10:59 AM
Edit	Immunization Tracking Record	10/12/2015	Medical Forms	Immunization Tracking Record	RN Medical	10/12/2015 08:51 AM

Follow document upload steps.


A message will be displayed indicating successful upload of the file.

The document will be listed in the table.


Parental Notification of Health-Related Care: General

Youth's Name:	<input type="text" value="Youth Name"/>	DOB:	<input type="text" value="DOB"/>	Sex:	Male	Race:	Black	DJJID:	<input type="text" value="DJJ ID"/>
---------------	---	------	----------------------------------	------	----------------------	-------	-----------------------	--------	-------------------------------------

DATE:

PARENT/GUARDIAN:* 

PARENT/GUARDIAN ADDRESS:

DJJ FACILITY:* 

DJJ FACILITY ADDRESS:

Dear

Our records indicate that you are the parent or guardian who has authority over health care for the above named youth. The purpose of this form is to notify you of changes in the health status of this youth.

The following health care treatment has been ordered or begun or the following health care event has occurred:

1000 characters remaining...

Signature of Health Care Provider Printed Name of Person Completing Form

Phone Number: () - Ext

Person to Contact:

☐ **** Copy of Notification to be filed in Individual Health Care Record.**

TO THE PARENT/GUARDIAN: IF THIS BOX IS CHECKED, THIS MEANS THAT YOU HAVE BEEN NOTIFIED BY PHONE OF THE HEALTH CARE TREATMENT ABOVE. WE NEED YOU TO GIVE YOUR CONSENT IN WRITING AND SEND THIS FORM BACK TO US AT THE FACILITY ADDRESS LISTED ABOVE. YOUR SIGNATURE INDICATES THAT YOU GIVE YOUR PERMISSION FOR US TO ADMINISTER THIS HEALTH CARE TREATMENT.

Select form from mandatory forms listing.
Complete information from the top down.
Click Elec. Sign Save>>.

This document must be mailed to Parent/Guardian for signature.

Parental Notification of Health-Related Care: General



Form: Parental Notification of Health-Related Care: General for

Youth Name/DJJ ID

Record Count: 2

New

Upload...

	Form	Ref#	Type	Program Name	Modified Date Time	Modified By	Status
Select			EMR Form	Alachua Regional Juvenile Detention Center	10/16/2015 03:22 PM	Medical, RN	Completed
Select			EMR Form	Alachua Regional Juvenile Detention Center	08/03/2015 09:27 AM	Arnold, Sharon B	Completed


Click the PDF icon for the General health care form to be mailed for parent/guardian signature.

Open and print form.

Parental Notification of Health-Related Care: General

Click the PDF icon for the General health care form to be mailed for parent/guardian signature.

Open and print form.



FLORIDA DEPARTMENT OF JUVENILE JUSTICE
PARENTAL NOTIFICATION OF
HEALTH-RELATED CARE: GENERAL

NAME OF YOUTH: Youth Name

DATE OF BIRTH: DOB

FACILITY NAME: Alachua Regional Juvenile Detention Center

DJJID#: DJJ ID

Date: 10/16/2015

PARENT/GUARDIAN NAME AND ADDRESS: Parent/Guardian

Address

DJJ FACILITY NAME AND ADDRESS: Alachua Regional Juvenile Detention Center

3440 Northeast 39th Avenue Gainesville, FL 32609

Dear Parent/Guardian :

Our records indicate that you are the parent or guardian who has authority over health care for the above named youth. The purpose of this form is to notify you of changes in the health status of this youth.

The following health care treatment has been ordered or begun or the following health care event has occurred:

Enter description of treatment or health care event.

Medical RN

Signature of Health Care Provider

Medical RN

Printed Name of Person Completing Form

If you have any concerns about the above information or do not want your child to receive this medication/treatment, notify the DJJ facility at the phone number indicated.

Phone Number: (850) 555-1212

Person to Contact: Medical RN


☐

TO THE PARENT/GUARDIAN: IF THIS BOX IS CHECKED, THIS MEANS THAT YOU HAVE BEEN NOTIFIED BY PHONE OF THE HEALTH CARE TREATMENT ABOVE. WE NEED YOU TO GIVE YOUR CONSENT IN WRITING AND SEND THIS FORM BACK TO US AT THE FACILITY ADDRESS LISTED ABOVE. YOUR SIGNATURE INDICATES THAT YOU GIVE YOUR PERMISSION FOR US TO ADMINISTER THIS HEALTH CARE TREATMENT.

Parent/Guardian Signature

Date

** Copy of Notification to be filed in Individual Health Care Record.


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Page 1 of 1

DJJ/OHSFEM 020 08/2015 63M-2

Revised 1/2014



Parental Notification of Health-Related Care: General

Form: Parental Notification of Health-Related Care: General for Youth Name/DJJ ID

Record Count: 2

New

Upload...

	Form	Ref#	Type	Program Name	Modified Date Time	Modified By	Status
Select			EMR Form	Alachua Regional Juvenile Detention Center	10/16/2015 03:22 PM	Medical, RN	Completed
Select			EMR Form	Alachua Regional Juvenile Detention Center	08/03/2015 09:27 AM	Arnold, Sharon B	Completed

DATE: 10/16/2015 03:21 PM

PARENT/GUARDIAN*: Parent/Guardian

PARENT/GUARDIAN ADDRESS: Address

DJJ FACILITY*: Alachua Regional Juvenile Detention Center

DJJ FACILITY ADDRESS: 3440 Northeast 39th Avenue Gainesville, FL 32609

Dear Parent/Guardian

Our records indicate that you are the parent or guardian who has authority over health care for the above named youth. The purpose of this form is to notify you of changes in the health status of this youth.

The following health care treatment has been ordered or begun or the following health care event has occurred:

Enter description of treatment or health care event.

948 characters remaining...

Check Spelling

Medical, RN

Signature of Health Care Provider

Phone Number: (850) 555 - 1212 Ext

Medical, RN, RN

Printed Name of Person Completing Form

Person to Contact: Medical RN

☐

**** Copy of Notification to be filed in Individual Health Care Record.**

TO THE PARENT/GUARDIAN: IF THIS BOX IS CHECKED, THIS MEANS THAT YOU HAVE BEEN NOTIFIED BY PHONE OF THE HEALTH CARE TREATMENT ABOVE. WE NEED YOU TO GIVE YOUR CONSENT IN WRITING AND SEND THIS FORM BACK TO US AT THE FACILITY ADDRESS LISTED ABOVE. YOUR SIGNATURE INDICATES THAT YOU GIVE YOUR PERMISSION FOR US TO ADMINISTER THIS HEALTH CARE TREATMENT.

Upload Document

No File Uploads for the Current Youth

When signed form is received from the Parent/Guardian, it must be uploaded to the EMR.

Click select for the general health care form to be uploaded with parent/guardian signature.

Click Upload Document to upload signed document.

Parental Notification of Health-Related Care: General

File Uploaded Successfully

[<< Back](#)

Name of Youth:

Date of Birth: DJJID#:

[Add New...](#)

	Document Name	Document Date	Category	Document Type	Modified By	Modified DateTime
Edit	Parental Notification of Health-Related Care: Gene	10/13/2015	Medical Forms	Parental Notification of Health-Related Care: General	RN Medical	10/22/2015 04:34 PM
Edit	Parental Notification of Health Related Care: Vacc	10/16/2015	Medical Forms	Parental Notification of Health Related Care: Vaccinations/Immunizations	RN Medical	10/16/2015 03:11 PM
Edit	Acknowledgment of Receipt of CPPN or Practitioner	10/15/2015	Medical Forms	Acknowledgment of Receipt of CPPN or Practitioner Form	RN Medical	10/15/2015 04:23 PM
Edit	Immunization Tracking Record	10/05/2015	Medical Forms	Immunization Tracking Record	RN Medical	10/14/2015 01:17 PM
Edit	Sexually Transmitted Infections Screening Form	10/12/2015	Medical Forms	Sexually Transmitted Infections Screening Form	RN Medical	10/12/2015 10:59 AM
Edit	Immunization Tracking Record	10/12/2015	Medical Forms	Immunization Tracking Record	RN Medical	10/12/2015 08:51 AM

Follow document upload steps.

A message will be displayed indicating successful upload of the file.

The document will be listed in the table.

Parental Notification of Health-Related Care: Medications

Youth's Name: DOB: Sex: [Male](#) Race: [Black](#) DJJID:

DATE: _____

PARENT/GUARDIAN*:

PARENT/GUARDIAN ADDRESS:

DJJ FACILITY*:

DJJ FACILITY ADDRESS: _____

Dear _____

Our records indicate that you are the parent(s) or guardian who has authority over health care for the above named youth. The purpose of this form is to notify you that a licensed health care practitioner has recommended the following medication or medication changes.

Medication Change*: Medication*:

Frequency*: Other Frequency:

Route*: Duration*:

Purpose*: 250 characters remaining...

Possible Side Effects: 125 characters remaining...

Phone Number: () - Ext Person to Contact:

Signature of Health Care Provider _____ Printed Name of Person Completing Form _____

☐ **TO THE PARENT/GUARDIAN: IF THIS BOX IS CHECKED, THIS MEANS THAT YOU HAVE BEEN NOTIFIED BY PHONE OF THE HEALTH CARE TREATMENT ABOVE. WE NEED YOU TO GIVE YOUR CONSENT IN WRITING AND SEND THIS FORM BACK TO US AT THE FACILITY ADDRESS LISTED ABOVE. YOUR SIGNATURE INDICATES THAT YOU GIVE YOUR PERMISSION FOR US TO ADMINISTER THIS HEALTH CARE TREATMENT.**

**** Copy of Notification to be filed in Individual Health Care Record.**

No File Uploads for the Current Youth

Select form from mandatory forms listing.
Complete information from the top down.
Click Elec. Sign Save>>.

This document must be mailed to Parent/Guardian for signature.

Parental Notification of Health-Related Care: Medications



Form: Parental Notification of Health-Related Care: Medications for

Youth Name/DJJ ID

Record Count: 2

New

Upload...




	Form	Ref#	Type	Program Name	Modified Date Time	Modified By	Status
Select			EMR Form	Alachua Regional Juvenile Detention Center	10/23/2015 01:26 PM	Medical, RN	Completed
Select			EMR Form	Alachua Regional Juvenile Detention Center	08/03/2015 09:24 AM	Arnold, Sharon B	Completed

Click the PDF icon for the Parental Notification of Health-Related Care: Medications form to be mailed for parent/guardian signature.

Open and print form.

Parental Notification of Health-Related Care: Medications

FLORIDA DEPARTMENT OF JUVENILE JUSTICE PARENTAL NOTIFICATION OF HEALTH-RELATED CARE: MEDICATION MANAGEMENT (Not for Psychotropic Medications)	
NAME OF YOUTH: <u>Youth Name</u>	DATE OF BIRTH: <u>DOB</u>
FACILITY NAME: <u>Alachua Regional Juvenile Detention Center</u>	DJJID#: <u>DJJ ID</u> Date: <u>10/23/2015</u>
PARENT/GUARDIAN NAME AND ADDRESS: <u>Parent/Guardian</u> <u>Address</u>	
DJJ FACILITY NAME AND ADDRESS: <u>Alachua Regional Juvenile Detention Center</u> <u>3440 Northeast 39th Avenue Gainesville, FL 32609</u>	
Dear <u>Parent/Guardian</u> :	
Our records indicate that you are the parent(s) or guardian who has authority over health care for the above named youth. The purpose of this form is to notify you that a licensed health care practitioner has recommended the following medication or medication changes.	
The following medication has been ordered, started or changed:	
Medication: <u>Penicillin (Pen-VK)</u>	Daily , Oral (by mouth) for <u>14</u> days
by _____ (route)	
Purpose: <u>Enter purpose here.</u>	
Possible Side Effects: <u>List any possible side effects.</u>	
<u>Medical,RN</u> Signature of Health Care Provider	<u>Medical,RN</u> Printed Name of Person Completing Form
<i>If you have any concerns about the above information or do not want your child to receive this medication/treatment, notify the DJJ facility at the phone number indicated.</i>	
Phone Number: <u>(850) 555-1212</u>	
Person to Contact: <u>Smith</u>	
<input checked="" type="checkbox"/> TO THE PARENT/GUARDIAN: IF THIS BOX IS CHECKED, THIS MEANS THAT YOU HAVE BEEN NOTIFIED BY PHONE OF THE HEALTH CARE TREATMENT ABOVE. WE NEED YOU TO GIVE YOUR CONSENT IN WRITING AND SEND THIS FORM BACK TO US AT THE FACILITY ADDRESS LISTED ABOVE. YOUR SIGNATURE INDICATES THAT YOU GIVE YOUR PERMISSION FOR US TO ADMINISTER THIS MEDICATION.	



DJJ/OHSFRM 021 10/2015 63M-2

HS 021
Page 1 of 2

Revised 1-2014

DJJ/OHSFRM 021 10/2015 63M-2

HS 021
Page 2 of 2

Revised 1-2014

Parent/Guardian Signature _____

Date _____

** Copy of Notification to be filed in Individual Health Care Record.

Parental Notification of Health-Related Care: Medications



Form: Parental Notification of Health-Related Care: Medications for

Youth Name/DJJ ID

Record Count: 2

New

Upload...

	Form	Ref#	Type	Program Name	Modified Date Time	Modified By	Status
Select			EMR Form	Alachua Regional Juvenile Detention Center	10/23/2015 01:26 PM	Medical, RN	Completed
Select			EMR Form	Alachua Regional Juvenile Detention Center	08/03/2015 09:24 AM	Arnold, Sharon B	Completed

Dear **Parent/Guardian**

Our records indicate that you are the parent(s) or guardian who has authority over health care for the above named youth. The purpose of this form is to notify you that a licensed health care practitioner has recommended the following medication or medication changes.

Medication Change: * Medication: *

Frequency: * Other Frequency:

Route: * Duration: *

Medication Period: *

Purpose: *

231 characters remaining...

Possible Side Effects:

94 characters remaining...

Phone Number: () - Ext Person to Contact:

Medical, RN Medical, RN, RN

Signature of Health Care Provider Printed Name of Person Completing Form

☒ TO THE PARENT/GUARDIAN: IF THIS BOX IS CHECKED, THIS MEANS THAT YOU HAVE BEEN NOTIFIED BY PHONE OF THE HEALTH CARE TREATMENT ABOVE. WE NEED YOU TO GIVE YOUR CONSENT IN WRITING AND SEND THIS FORM BACK TO US AT THE FACILITY ADDRESS LISTED ABOVE. YOUR SIGNATURE INDICATES THAT YOU GIVE YOUR PERMISSION FOR US TO ADMINISTER THIS HEALTH CARE TREATMENT.

**** Copy of Notification to be filed in Individual Health Care Record.**

No File Uploads for the Current Youth

When signed form is received from the Parent/Guardian, it must be uploaded to the EMR.

Click select for the Parental Notification of Health-Related Care: Medications form to be uploaded with parent/guardian signature.

Click Upload Document to upload signed document.

Parental Notification of Health-Related Care: Medications

File Uploaded Successfully

[<< Back](#)

Name of Youth:

Date of Birth: DJJID#:

[Add New...](#)

	Document Name	Document Date	Category	Document Type	Modified By	Modified DateTime
Edit	Parental Notification of Health-Related Care: Medi	10/23/2015	Medical Forms	Parental Notification of Health-Related Care: Medications	RN Medical	10/23/2015 01:43 PM
Edit	Parental Notification of Health-Related Care: Gene	10/13/2015	Medical Forms	Parental Notification of Health-Related Care: General	RN Medical	10/22/2015 04:34 PM
Edit	Parental Notification of Health Related Care: Vacc	10/16/2015	Medical Forms	Parental Notification of Health Related Care: Vaccinations/Immunizations	RN Medical	10/16/2015 03:11 PM
Edit	Acknowledgment of Receipt of CPPN or Practitioner	10/15/2015	Medical Forms	Acknowledgment of Receipt of CPPN or Practitioner Form	RN Medical	10/15/2015 04:23 PM
Edit	Immunization Tracking Record	10/05/2015	Medical Forms	Immunization Tracking Record	RN Medical	10/14/2015 01:17 PM
Edit	Sexually Transmitted Infections Screening Form	10/12/2015	Medical Forms	Sexually Transmitted Infections Screening Form	RN Medical	10/12/2015 10:59 AM
Edit	Immunization Tracking Record	10/12/2015	Medical Forms	Immunization Tracking Record	RN Medical	10/12/2015 08:51 AM

Follow document upload steps.

A message will be displayed indicating successful upload of the file.

The document will be listed in the table.

Personal and Health Related Information

Core Profile

Mandatory/Required Forms

- ☐ Acknowledgment of Receipt of CPPN or Practitioner Form (PDF)
- ☐ Affidavit of Diligent Effort (PDF)
- ☐ Authority For Evaluation and Treatment
- ☐ Body Chart
- ☐ Clinical Psychotropic Progress Note (PDF)
- ☐ Clinical Psychotropic Progress Note Part B (PDF)
- ☐ Comprehensive Physical Assessment
- ☐ Controlled Medication Inventory Record (PDF)
- ☐ Custody of Individual Health Care Record (PDF)
- ☐ Facility Entry Physical Health Screening
- ☐ Health Discharge Summary – Transfer Note (PDF)
- ☐ Health Education Record
- ☐ Health Related History
- ☐ Immunization Tracking Record
- ☐ Individual Health Care Record Checklist and Internal Quality Control
- ☐ Infectious and Communicable Disease Form
- ☐ Limited Consent for Evaluation and Treatment (PDF)
- ☐ *Medication And Treatment Record*
- ☐ *Medications*
- ☐ Oral Health Assessment
- ☐ Parental Notification of Health Related Care: Vaccinations/Immunizations
- ☐ Parental Notification of Health-Related Care: General
- ☐ Parental Notification of Health-Related Care: Medications
- ☐ Personal and Health Related Information
- ☐ Problem List
- ☐ Sexually Transmitted Infections Screening Form
- ☐ Sick Call Index (PDF)
- ☐ ***Sick Call Initiation***
- ☐ *Sick Call Review*
- ☐ Summary of Off-Site Care (PDF)

Recommended Forms

This form included in Core Profile.
See the OHS – EMR – Medical Staff – Core Profile
power point for instructions.

Problem List

Core Profile

Mandatory/Required Forms

-  Acknowledgment of Receipt of CPPN or Practitioner Form (PDF)
-  Affidavit of Diligent Effort (PDF)
-  Authority For Evaluation and Treatment
-  Body Chart
-  Clinical Psychotropic Progress Note (PDF)
-  Clinical Psychotropic Progress Note Part B (PDF)
-  Comprehensive Physical Assessment
-  Controlled Medication Inventory Record (PDF)
-  Custody of Individual Health Care Record (PDF)
-  Facility Entry Physical Health Screening
-  Health Discharge Summary – Transfer Note (PDF)
-  Health Education Record
-  Health Related History
-  Immunization Tracking Record
-  Individual Health Care Record Checklist and Internal Quality Control
-  Infectious and Communicable Disease Form
-  Limited Consent for Evaluation and Treatment (PDF)
-  *Medication And Treatment Record*
-  *Medications*
-  Oral Health Assessment
-  Parental Notification of Health Related Care: Vaccinations/Immunizations
-  Parental Notification of Health-Related Care: General
-  Parental Notification of Health-Related Care: Medications
-  Personal and Health Related Information
-  Problem List
-  Sexually Transmitted Infections Screening Form
-  Sick Call Index (PDF)
-  ***Sick Call Initiation***
-  *Sick Call Review*
-  Summary of Off-Site Care (PDF)

Recommended Forms

This form included in Core Profile.
See the OHS – EMR – Medical Staff – Core Profile
power point for instructions.

Sexually Transmitted Infections Screening Form

Core Profile


Mandatory/Required Forms

- ☐ Acknowledgment of Receipt of CPPN or Practitioner Form (PDF)
- ☐ Affidavit of Diligent Effort (PDF)
- ☐ Authority For Evaluation and Treatment
- ☐ Body Chart
- ☐ Clinical Psychotropic Progress Note (PDF)
- ☐ Clinical Psychotropic Progress Note Part B (PDF)
- ☐ Comprehensive Physical Assessment
- ☐ Controlled Medication Inventory Record (PDF)
- ☐ Custody of Individual Health Care Record (PDF)
- ☐ Facility Entry Physical Health Screening
- ☐ Health Discharge Summary – Transfer Note (PDF)
- ☐ Health Education Record
- ☐ Health Related History
- ☐ Immunization Tracking Record
- ☐ Individual Health Care Record Checklist and Internal Quality Control
- ☐ Infectious and Communicable Disease Form
- ☐ Limited Consent for Evaluation and Treatment (PDF)
- ☐ *Medication And Treatment Record*
- ☐ *Medications*
- ☐ Oral Health Assessment
- ☐ Parental Notification of Health Related Care: Vaccinations/Immunizations
- ☐ Parental Notification of Health-Related Care: General
- ☐ Parental Notification of Health-Related Care: Medications
- ☐ Personal and Health Related Information
- ☐ Problem List
- ☐ Sexually Transmitted Infections Screening Form
- ☐ Sick Call Index (PDF)
- ☐ ***Sick Call Initiation***
- ☐ *Sick Call Review*
- ☐ Summary of Off-Site Care (PDF)

Recommended Forms

This form included in Core Profile.
See the OHS – EMR – Medical Staff – Core Profile
power point for instructions.

Sick Call Index (PDF)



FLORIDA DEPARTMENT OF JUVENILE JUSTICE

SICK CALL INDEX

Please complete one form per youth

NAME OF YOUTH: Youth Name

DJJID#: DJJ ID

DATE OF BIRTH: DOB

PURPOSE


The purpose of this form is the chronological listing of a youth's sick call complaints so that health care providers may have a concise record of recent or recurring complaints. This record does not take the place of the detailed entry of sick call care, which is included in the chronological progress notes of the Individual Health Care Record. This is an index only to the sick call complaints.

INSTRUCTIONS

A sick call complaint is listed as it occurs. The date of the occurrence and the facility are both entered. Complaints, which occur more than once, are not listed again, but the subsequent dates of occurrence and the facilities are filled in. Any sick call complaint for which the youth seeks care on three or more occasions during a two-week period MUST result in an assessment by a licensed healthcare professional (MD, PA, or ARNP). This includes physical health complaints, mental health complaints, and dental health complaints. Referrals for assessment by a licensed health care professional (MD, PA, or ARNP) MUST be made AT ANY TIME that the seriousness of the youth's sick call complaint cannot be determined, or if the youth has a chronic condition (for example, seizure disorder, asthma, diabetes, possible side effects of prescribed medication) and the sick call complaint is related to that chronic condition.

OCCURRENCES AND FACILITY

SICK CALL COMPLAINT	DATE	FACILITY
per officer, refused sick call	04/06/2014	Alachua Regional Juvenile Detention Center
Headache resolved	04/08/2014	Alachua Regional Juvenile Detention Center
Duplicate	04/09/2014	Alachua Regional Juvenile Detention Center



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Page 1 of 1


DJJ/OHSFRM 030 06/2014 63M-1

Revised October 2006

Sick call requests automatically populate on the index.

The Sick Call Index should be printed and added to the IHCR.

Sick Call Initiation



DEPARTMENT OF JUVENILE JUSTICE
Electronic Medical Records

User Role: Medical RN

[Home](#)**Active Youth: Please select the Youth.**[Logout](#)

Youth Search

Active Program:
Escambia Regional Juvenile Detention Center

Escambia Regional Juvenile Detention Center
Facility Youth Listing: (32 total)

Youth Names/ DJJ IDs

OHS Management Reports

MH Referral / Sick Call / MH Review


Mental Health Forms

Medical Forms

Upload Library

Youth History

Pending Actions - 0



OUR VISION
The children and families of Florida will live in safe, nurturing communities that provide for their needs, recognize their strengths and support their success.

OUR MISSION
To increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services that strengthen families and turn around the lives of troubled youth.

Sick Call Initiation can be accessed two ways:

- From the Mandatory/Required Forms list under Medical Forms
- From the MH Referral / Sick Call / MH Review Link

Sick Call Initiation

Youth Search is available for use if
the youth is not listed.
(Always check Detention youth
listing prior to search)

The screenshot shows a web application interface for Sick Call Initiation. At the top, there is a header with a logo on the left, the word "DEPARTMENT" in the center, and "User Role: Medical RN" on the right. Below the header, there is a navigation bar with a "Home" link and a status message: "Active Youth: Please select the Youth." with a "Logout" link. The main content area is divided into two sections. On the left, there is a sidebar with a "Youth Search" button and a dropdown menu for "Active Program:" set to "Collier Regional Juvenile Detention Center". Below this, it says "Collier Regional Juvenile Detention Center" and "Facility Youth Listing: (25 total)". A blue box with the text "Facility Youth listed here" is overlaid on this section. On the right, there is a search form. It starts with a red message: "Please minimize number of upper case letters to retain report layout." followed by a "Search Type" section with radio buttons for "Approximate Match" (selected) and "Exact Match". Below that is a "Search By" section with several radio button options: "Last Name, First Name" (selected), "Last Name, First Name, Race", "Last Name, First Name, Sex", "Last Name, First Name, DOB", "Alias Name", "Social Security #", "Date of Birth", and "DJJ ID". Each option is followed by a corresponding input field: "Last Name", "First Name", "Alias", "Sex" (a dropdown menu), "SSN", "DOB", "DJJ ID", and "Race". A "Find" button is located at the bottom right of the search form. At the very bottom, there is a section labeled "Youth Found" and "Record Count:".

DEPARTMENT

User Role: Medical RN

[Home](#)

Active Youth: **Please select the Youth.** [Logout](#)

Youth Search

Active Program:
Collier Regional Juvenile Detention Center

Collier Regional Juvenile Detention Center
Facility Youth Listing: (25 total)

Please minimize number of upper case letters to retain report layout.

Search Type
☒ Approximate Match ☐ Exact Match

Search By

☒ Last Name, First Name
☐ Last Name, First Name, DOB

☐ Last Name, First Name, Race
☐ Last Name, First Name, Sex

☐ Alias Name
☐ Social Security #

☐ Date of Birth
☐ DJJ ID

Last Name

First Name

Alias

Sex

SSN

DOB

DJJ ID

Race

Find

Youth Found

Record Count:

Facility Youth listed here

Sick Call Initiation

>> Please minimize number of upper case letters to retain report layout.

Youth's Name:	Youth Name	DOB:	DOB	Sex:	Male	Race:	White	DJJID:	DJJ ID
---------------	------------	------	-----	------	------	-------	-------	--------	--------

Facility Name: *	Collier Regional Juvenile Detention Center	Select Facility
------------------	--	-----------------

Date of Request: *	8/29/2014	Requested Time: *	10:30 AM
--------------------	-----------	-------------------	----------

Request for: *	<input checked="" type="checkbox"/> Medical Care	<input type="checkbox"/> Dental Care	<input type="checkbox"/> Mental Health Care
----------------	--	--------------------------------------	---

Please describe your problem: *

Youth has a backache

280 characters remaining...

Check Spelling

Detention Staff observations:

Staff observed youth holding back in pain

2459 characters remaining...

Check Spelling

Submit Sick Call Request Cancel

Date and time of Request - This is the date and time youth made the request, not the time request is being entered in JJIS. This field defaults to current date

Select Request type: Medical OR Dental (Can submit both requests on 1 form)

If Mental Health Care is selected a mental health referral must also be completed

Describe Problem This is based from youth's sick form (or verbal request) and description of problem. **300 characters**)

Detention staff observations - Based on what staff has observed as it relates to request **2500 characters. WILL NOT SHOW ON PRINTED FORM .**

Sick Call Initiation

Facility Name: * Collier Regional Juvenile Detention Center Select Facility

Date of Request: * 8/29/2014 Requested Time: * 10:30 AM

Request for: * ☐ Medical Care ☐ Dental Care ☒ Mental Health Care

Alert for Mental Health Care

Do you want to complete a Mental Health Referral Summary form? If so, go to Mental Health Practice menu.

OK

2459 characters remaining... Check Spelling

Submit Sick Call Request Cancel

Selecting Mental Health Care presents an alert notifying staff to complete a Mental Health Referral Summary

Click OK to dismiss alert and return to the Sick Call Request

Sick Call Initiation

Facility Name: * Collier Regional Juvenile Detention Center Select Facility

Date of Request: * 8/29/2014 Requested Time: * 10:30 AM

Request for: * ☒ Medical Care ☐ Dental Care ☐ Mental Health Care

Please describe your problem: *

Youth has a backache

280 characters remaining

Detention Staff observations:

Staff observed youth holding back in pain

2459 characters remaining...

Submit Sick Call Request Cancel

Message from webpage

Are you sure you want to Submit "Sick Call Request"?

OK Cancel

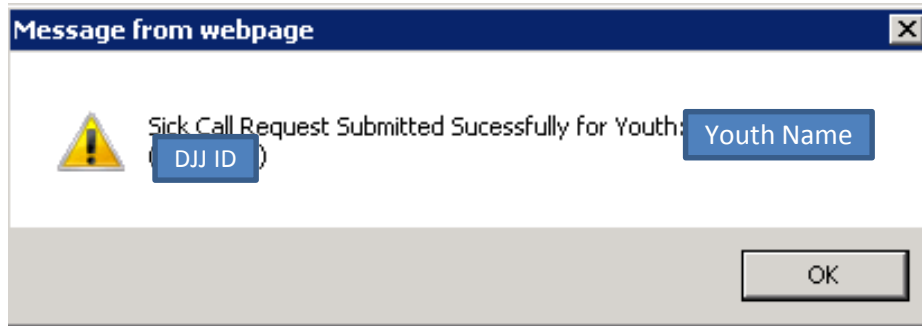
Check Spelling

Check Spelling

Click "Submit Sick Call Request" to submit
"Cancel" clears entries from the form

Click "OK" to submit
"Cancel" returns user to sick call page with no save/submission


Sick Call Initiation



When you submit, you should get a message box indicating the submission was successful.

- As long as this message appears, Staff will not get any other feedback from JJIS about the sick call.
- ❖ Once the sick call is initiated, it will generate an email to nurse, and / or JDOS, Superintendent/ Designee. If no nurse, the JDOS will follow up to triage youth.
 - ❖ If you need to enter a second sick call request, find youth and repeat the process to complete another form.

Sick Call Review



DEPARTMENT OF JUVENILE JUSTICE
Electronic Medical Records

User Role: Medical RN

[Home](#)**Active Youth: Please select the Youth.**[Logout](#)

Youth Search

Active Program:
Escambia Regional Juvenile Detention Center

Escambia Regional Juvenile Detention Center
Facility Youth Listing: (32 total)

Youth Names/ DJJ IDs

OHS Management Reports

MH Referral / Sick Call / MH Review

Mental Health Forms

Medical Forms

Upload Library

Youth History

Pending Actions - 0



OUR VISION
The children and families of Florida will live in safe, nurturing communities that provide for their needs, recognize their strengths and support their success.

OUR MISSION
To increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services that strengthen families and turn around the lives of troubled youth.

Sick Call Review can be accessed two ways:

- From the Mandatory/Required Forms list under Medical Forms
- From the MH Referral / Sick Call / MH Review Link

Sick Call Review

DEPARTMENT OF JUVENILE JUSTICE
Electronic Medical Records
MH REFERRAL / SICK CALL

User Role: Medical ARNP

Home Active Youth: **Please select the Youth.** Logout

YOUTH SEARCH << Please minimize number of upper case letters to retain report layout.

Active Program:
Collier Regional Juvenile Detention Center

Collier Regional Juvenile Detention Center

Stfort, Willair (1310106)

OHS Management Reports

MH Referral / Sick Call

Mental Health Forms

Medical Forms

Upload Library

Youth History

Pending Actions - 0

MH Referral:

- [MH/SA Referral Summary](#)
- [MH/SA Referral Review](#)

Sick Call:

- [Sick Call Initiation](#)
- [Sick Call Review](#)

To view sick calls (Open, pending, or closed):

1. Select MH Referral / Sick Call
2. select "Sick Call Review"
3. select Open, Pending Review, or Closed from Drop down box.
4. Select Current Facility List or All Facility List

This will populate a list for the entire Detention Center selected.

DEPARTMENT OF JUVENILE JUSTICE
Electronic Medical Records
SICK CALL REVIEW

User Role: Medical ARNP

Home Active Youth: **Please select the Y** Logout

>>

Status: Open Pending Review Closed Sick Call


Sick Call List For: All Youths

☒ Current Facility List ☐ All Facility List

<< Back Add New Sick Call

Youth Name	DJJID	Complaint	Status	Created By	Created Date & Time	Elec.Sig By Medical Staff	Elec.Sig Date Medical Staff
No records found.							

Sick Call Review

 **DEPARTMENT OF JUVENILE JUSTICE**
Electronic Medical Records
MH REFERRAL / SICK CALL

Home **Active Youth: Please select the Youth.** User Role: Medical ARNP [Logout](#)

YOUTH SEARCH

Active Program:
Collier Regional Juvenile Detention Center
Collier Regional Juvenile Detention Center
Facility Youth Listing: (12 total)

Facility Youth listed here

OHS Management Reports
MH Referral / Sick Call
Mental Health Forms
Medical Forms
Upload Library
Youth History
Pending Actions - 0

<< Please minimize number of upper case letters to retain report layout.


MH Referral:

- [MH/SA Referral Summary](#)
- [MH/SA Referral Review](#)

Sick Call:

- [Sick Call Initiation](#)
- [Sick Call Review](#)

1. Select MH Referral / Sick Call
2. Select Sick Call Review, as default lists all "open" sick calls
3. There is a drop down box for options to see open, pending, and closed calls
4. Select from Current Facility List or All Facility List
5. Add New Sick Call

 **DEPARTMENT OF JUVENILE JUSTICE**
Electronic Medical Records
SICK CALL REVIEW

Home **Active Youth: Please select the Youth.** User Role: Medical ARNP [Logout](#)

>>

Status: **Open** Sick Call List For: All Youths ☒ Current Facility List ☐ All Facility List << Back Add New Sick Call

Sick Call: Pending Review
Closed

Youth Name	DJJID	Complaint	Status	Created By	Created Date & Time	Elec.Sig By Medical Staff	Elec.Sig Date Medical Staff
No records found.							

Sick Call Review



DEPARTMENT OF JUVENILE JUSTICE Electronic Medical Records SICK CALL REVIEW

User Role: Medical ARNP

[Home](#)

Active Youth: **Please select the Youth.**

[Logout](#)

>>

Status:

Sick Call List For:

☒ Current Facility List ☐ All Facility List

<< Back

Add New Sick Call

Sick Call Review List

	Report	Youth Name	DJJID	Program Name	Problem Description	Status	Created By	Created Date	Elec.Sig By Medical Staff	Elec.Sig Date Medical Staff
Select		Youth Names / DJJ IDs		Volusia Regional Juvenile Detention Center	youth stated that she was not ...	Open	Christina Miles	09/03/2014 03:00 PM		

1

2

1. You can select the sick call to complete or you can view the report [click on PDF in report column]
2. To see all pending review sick calls select pending in drop down and then click select next to youth's name to complete review.

Status:

Sick Call List For:

☐ Current Facility List ☒ All Facility List

Sick Call Review List

	Report	Youth Name	DJJID	Program Name	Problem Description	Status	Created By	Created Date	Elec.Sig By Medical Staff	Elec.Sig Date Medical Staff
Select		Youth Names / DJJ IDs		Duval Regional Juvenile Detention Center	This is a test.	Pending Review	Tiffany Greene	09/10/2014 09:31 AM	Tiffany Greene	09/10/2014 09:38 AM
Select				St. Lucie Regional Juvenile Detention Center	Youth stubbed right great toe ...	Pending Review	Donna Caldwell	09/03/2014 04:53 PM	Donna Caldwell	09/03/2014 05:02 PM
Select				Miami - Dade Regional Juvenile Detention Center	Youth has c/o a headache.	Pending Review	Thomas Adams	09/03/2014 01:22 PM	Thomas Adams	09/03/2014 01:24 PM

Sick Call Review

>>

1 Youth's Name: **Youth Name** 2 DOB: **DOB** Sex: **Male** Race: **Black** DJJID: **DJJ ID**

Sick Call Initiation Interventions Medical / Clinical Staff 3 << Back << Sick Call List Report

Facility Name: Bay Regional Juvenile Detention Center

Date of Request: * 9/25/2014 Requested Time: * 03:22 PM

Request for: * ☒ Medical Care ☐ Dental Care ☐ Mental Health Care

Please describe your problem: *

Youth states he has migraines.

270 characters remaining...

Check Spelling

Detention Staff observations:

Youth frowning while holding his forehead.

2458 characters remaining...

Check Spelling

1. Sick Call Initiation – allows medical staff to review problems & observations submitted [can be edited]
2. Intervention – show any interventions completed by Superintendent or Designee [view only for Medical]
3. Medical/Clinical Staff – this is where medical staff document what was done for this specific sick call

Sick Call Review

>> Please minimize number of upper case letters to retain report layout.

Youth's Name:	Youth Name	DOB:	DOB	Sex:	Male	Race:	Black	DJJID:	DJJ ID								
Sick Call Initiation	Interventions	Medical / Clinical Staff	<< Back			<< Sick Call List		Report									
Intervention List:																	
<table><thead><tr><th></th><th>Intervention Comments</th><th>Created By</th><th>Created Date & Time</th></tr></thead><tbody><tr><td colspan="4">No records found.</td></tr></tbody></table>											Intervention Comments	Created By	Created Date & Time	No records found.			
	Intervention Comments	Created By	Created Date & Time														
No records found.																	

Interventions - will show any interventions completed by Superintendent or Designee for this youth. For Medical this tab is "view only".

Report – Generates PDF report on progression of sick call status.

<< Sick Call List will return the user back to the pending sick call list

Sick Call Review

>> Please minimize number of upper case letters to retain report layout.

Youth's Name:	Youth Name	DOB:	DOB	Sex:	Male	Race:	Black	DJJID:	DJJ ID	
Sick Call Initiation		Interventions		Medical / Clinical Staff		<< Back		<< Sick Call List		Report


frmSQLDJIS0HSickCallReq2[1].pdf - Adobe Reader

File Edit View Window Help

1 / 1 102%

Sign Comment

Created Date & Time

**FLORIDA DEPARTMENT OF JUVENILE JUSTICE**
SICK CALL REQUEST
YOUTH: Please fill in the following information as clearly as possible.
NAME OF YOUTH: Youth test DJJID# DJJ ID DOB: DOB
Facility Name: Collier Regional Juvenile Detention Center
Male ☒ Female ☐ Date of Request: 07/03/2013 08:00 AM
Request for: ☒ MEDICAL CARE ☐ DENTAL CARE ☐ MENTAL HEALTH CARE
Please describe your problem:
Youth has backache
YOUTH: Please do not write below this line.
TRIAGE: ☒ RN ☐ ARNP/PA ☐ Dental Hygienist ☐ Mental Health Staff
☐ LPN ☐ Physician ☐ Dentist ☐ Other Date Received 07/03/2013
DISPOSITION:
Subjective: Youth is holding his back and complaining of a dull ache - What the youth is actually saying or complaining about
Objective: BP: 110/60 Pulse: 82 Temp: 98.6 Respirations: 20 Weight: 166
nurses observations and assessment results should be inputted here

Report –
Generates PDF
report on
progression of
sick call status.

Sick Call Interventions

Youth's Name: DOB: Sex: Male Race: Black DJJID:

Sick Call Initiation **Interventions** << Back << Sick Call List Report

Intervention List: Add Intervention

Select	Intervention Comments	Created By	Created Date
Select	Youth given 400mg acetaminophen OTC. 9/18/14, 10:00pm	Rosellyn Hutchins	09/26/2014 03:05 PM

Supervisor Intervention

Is Nurse on site: * ☐ Yes ☒ No

* ☒ Determined youth safe - continue for nurse to see youth ☐ Youth sent off-site for emergency care ☐ DHA notified

Intervention applied: * (Please include event Date & Time)

Youth status reviewed. States he is feeling better. 9/19/14, 06:00am

1930 characters remaining... Check Spelling

Save Intervention Cancel

>> Please minimize number of upper case letters to retain report layout.

Supervisor Interventions saved successfully.

Youth's Name: DOB: Sex: Male Race: Black DJJID:

Sick Call Initiation **Interventions** << Back << Sick Call List Report

Intervention List: Add Intervention

Select	Intervention Comments	Created By	Created Date
Select	Youth given 400mg acetaminophen OTC. 9/18/14, 10:00pm	Rosellyn Hutchins	09/26/2014 03:05 PM
Select	Youth status reviewed. States he is feeling better. 9/19/14, 06:00am	Rosellyn Hutchins	09/29/2014 08:38 AM

Superintendent or Designee Staff **will review all sick calls within 4 hours** and complete an Intervention(s). This is documented in the OHS Web Forms module in JJIS.

Select "Add Intervention" and then complete required fields. Any action taken should be documented in the intervention applied text box.

Once completed, the Superintendent or Designee will select save and a green save message shows.

If there are additional interventions they complete the process again.

If an intervention was completed (such as medication given, ice, etc.) make sure to go back and document if the intervention was effective.

Sick Call Interventions

Sick Call Initiation Interventions **Medical / Clinical Staff** << Back << Sick Call List Report

Medical Section

TRIAGE: * ☒ RN ☐ ARNP/PA ☐ Dental Hygienist ☐ Mental Health Staff
☐ LPN ☐ Physician ☐ Dentist ☐ Other Date Received: * 7/3/2013

Subjective: *
Youth is holding his back and complaining of a dull ache - What the youth is actually saying or complaining about
887 characters remaining... Check Spelling

Objective: * BP: 110/60 * Pulse: 82 * Temp: 98.6 * Respirations: 20 * Weight: 166
* nurses observations and assessment results should be inputted here
934 characters remaining... Check Spelling

Nursing Diagnosis
Alteration In: * comfort
Related To: * backache

Assessment: *
Findings should be inputted related to sick call/problem
944 characters remaining... Check Spelling

Plan (Indicate if per protocol): *
All steps medical would take to treat youth
1. urinalysis dipstick
2. notify Dr.
3. medical bed rest until seen by MD
4. increase fluids
5. gave two Advil according to backache protocol
806 characters remaining...

Detainee instructed to return to medical if symptoms continue or worsen? * ☒ Yes ☐ No
Education provided on treatment plan / prescribed protocol and medication? ☒ Yes ☐ No

Date Seen: * 7/3/2013 Time: * 10:00 AM

Elec.Sign & Save >>
Person Completing form (Licensed Staff) Signature/Date

Save Cancel

Medical/Clinical Staff

Medical Staff will complete all fields listed starting from top to bottom. All fields with Red “*” are mandatory. Once completed medical staff will select “ Elec. Sign and Save”

Confirm your name and enter JJIS password to confirm Electronic Signature and Save.

Electronic Signature

By clicking Elec.Sign and Save, I agree that the signature will be the electronic representation of my signature.

Confirm your name and signature.

Your Name: Lee Medical

Lee Medical

Enter your JJIS password for Confirmation.

password:

Elec.Sign and Save

Cancel

Sick Call Interventions

>> Please minimize number of upper case letters to retain report layout.

Medical section information updated successfully.

Youth's Name: **Youth Name** DOB: **DOB** Sex: Male Race: Black DJJID: **DJJID**

Sick Call Initiation Interventions **Medical / Clinical Staff** << Back << Sick Call List Report

Medical Section

TRIAGE:* ☒ RN ☐ ARNP/PA ☐ Dental Hygienist ☐ Mental Health Staff
☐ LPN ☐ Physician ☐ Dentist ☐ Other

Date Received:* 9/19/2014 **Time:** 09:00 AM

Subjective:*
Type stuff here
985 characters remaining... **Check Spelling**

Objective: * BP: 110/60 * Pulse: 82 * Temp: 98.6 * Respirations: 20 * Weight: 166

Once saved/signed the user should see this message in green. If there are errors or missing data, red error messages will appear directing the user to correct the issue.

Detainee instructed to return to medical if symptoms continue or worsen? * ☒ Yes ☐ No

Education provided on treatment plan / prescribed protocol and medication? * ☒ Yes ☐ No

Date Seen: * 9/19/2014 **Time: *** 10:00 AM

Rosellyn Hutchins 09/29/2014

Person Completing form (Licensed Staff) Signature/Date

<< Electronic Signature
Appears

Sick Call Interventions - LPN

ices Web Forms - Microsoft Internet Explorer provided by Department of Juvenile Justice

Objective: * BP: 110/80 * Pulse: 80 * Temp: 101 * Respirations: 20 * Weight: 345

* Face swollen on right side, nose bent upwards

955 characters remaining... [Check Spelling](#)

Nursing Diagnosis

Alteration In: * in air exchange

Related To: * bent nose

Assessment: *

Possible fractured nose and right orbit

961 characters remaining... [Check Spelling](#)

Plan (Indicate if per protocol): *

Notify MD, schedule X-ray, soft food diet, ice for face and nose, medical bed rest, no back flips

903 characters remaining... [Check Spelling](#)

Detainee instructed to return to medical if symptoms continue or worsen? * ☒ Yes ☐ No

Education provided on treatment plan / prescribed protocol and medication? * ☐ Yes ☒ No

Date Seen: * 7/3/2013 Time: * 11:00 AM

[Elec.Sign & Save >>](#)

Review Process

Have you had Telephonic or Electronic Review? * ☐ Yes ☐ No

Contact Type * ...

Contact Person Name *

Contact Date: * Time: *

Reviewer Comments: *

2500 characters remaining... [Check Spelling](#)

* ☐ Referred ☐ Resolved

Referred (OR) Resolved Comments: *

1000 characters remaining... [Check Spelling](#)

[Comments History \(Hide History Data...\)](#)

Referred (OR) Resolved Comments History	Created By	Created Date
No records found.		

[Elec.Sign & Save >>](#)

Reviewer Signature/Date

[Save](#) [Cancel](#)




NOTE

Under Plan section, the LPN should document contact with RN or higher. LPN will also have to document the review process if an RN or higher will not be documenting their review in JJIS. LPN's have a different screen to complete.

SICK CALL INTERVENTIONS

Status: Pending Review Sick Call List For: All Youths ☐ Current Facility List ☒ All Facility List << Back Add New Sick Call

Sick Call Review List

	Report	Youth Name	DJJID	Program Name	Problem Description	Status	Created By	Created Date	Elec.Sig By Medical Staff	Elec.Sig Date Medical Staff
Select		Duval Regional Juvenile Detention Center			This is a test.	Pending Review	Tiffany Greene	09/10/2014 09:31 AM	Tiffany Greene	09/10/2014 09:38 AM
Select		St. Lucie Regional Juvenile Detention Center			Youth stubbed right great toe ...	Pending Review	Donna Caldwell	09/03/2014 04:53 PM	Donna Caldwell	09/03/2014 05:02 PM
Select		Miami - Dade Regional Juvenile Detention Center			Youth has c/o a headache.	Pending Review	Thomas Adams	09/03/2014 01:22 PM	Thomas Adams	09/03/2014 01:24 PM

Youth pending review will be listed here

Sick Call Initiation Interventions **Medical / Clinical Staff** << Back << Sick Call List Report

Date of Request: 7/9/2013 Requested Time: 08:00 AM

Request for: ☒ Medical Care ☐ Dental Care ☐ Mental Health Care

Please describe your problem:

Rash around the face and neck that is itchy

256 characters remaining... Check Spelling

Detention Staff observations:

See rash around neck and face with red marks

2456 characters remaining... Check Spelling

Reviewer Comments:

2500 characters remaining... Check Spelling

☒ Referred ☐ Resolved

Referred (OR) Resolved Comments:

1000 characters remaining... Check Spelling

Comments History (Hide History Data)

Referred (OR) Resolved Comments History	Created By	Created Date
No records found.		

Elec.Sign & Save >>

Reviewer Signature/Date

Save Cancel

Pending Review

To find sick calls needing review
Select drop down box "pending review"

This will list all calls pending review status

Click on adobe icon to see report
Click on "Select" to start review process

Select Medical Tab to input reviewer comments and Referred or Resolved comments.

Then complete with Electronic Sign and Save.

SICK CALL INTERVENTIONS

Lee Medical 07/03/2013

Person Completing form (Licensed Staff) Signature/Date

Review Process

Reviewer Comments:*

Text area for Reviewer Comments.

2500 characters remaining...

Check Spelling

* ☐ Referred ☐ Resolved

Referred (OR) Resolved Comments:*

Text area for Referred (OR) Resolved Comments.

1000 characters remaining...

Check Spelling

Comments History (Hide History Data...)

Referred (OR) Resolved Comments History	Created By	Created Date
No records found.		

Elec.Sign & Save >>

Reviewer Signature/Date

Save

Cancel

RN or Higher Review Process

Enter Comments

Then select Referred or Resolved and input comments

Then Electronic Sign & Save

SICK CALL INTERVENTIONS

Lee Medical 07/03/2013
Person Completing form (Licensed Staff) Signature/Date

Review Process

Reviewer Comments:*

RN/higher will input comments and update this section.
Example:
Youth was treated appropriately according to protocol

2380 characters remaining... [Check Spelling](#)

* ☒ Referred ☐ Resolved

Referred (OR) Resolved Comments:*

Youth referred to Emergency Room for X-rays and possible broken nose

932 characters remaining... [Check Spelling](#)

[Comments History \(Hide History Data...\)](#)

Referred (OR) Resolved Comments History	Created By	Created Date
No records found.		

[Elec.Sign & Save >>](#)

Reviewer Signature/Date

RN or Higher can update and complete review process and then electronically approve/sign the work completed by themselves or an LPN

Electronic Signature

By clicking Elec.Sign and Save, I agree that the signature will be the electronic representation of my signature.

Confirm your name and signature.

Your Name:

Lee Medical

Enter your JJIS password for Confirmation.

password:

[Elec.Sign and Save](#)

[Cancel](#)

SICK CALL INTERVENTIONS - LPN

Review Process

Have you had Telephonic or Electronic Review? * ☐ Yes ☐ No

Contact Type *

Contact Person Name *

Contact Date: * Time: *

Reviewer Comments: *

2500 characters remaining... [Check Spelling](#)

☐ Referred ☐ Resolved

Referred (OR) Resolved Comments: *

1000 characters remaining... [Check Spelling](#)

[Comments History \(Hide History Data...\)](#)

Referred (OR) Resolved Comments History	Created By	Created Date
No records found.		

[Elec.Sign & Save >>](#)

Reviewer Signature/Date

[Save](#) [Cancel](#)

LPN Review

LPNs will document contact type (electronic, telephonic, face to face)

Document the Contact person and enter date & time

LPN will document reviewer comments

LPN will select Referred or Resolved adding comments

LPN will electronically approve/sign the work completed.

Electronic Signature

By clicking **Elec.Sign** and **Save**, I agree that the signature will be the electronic representation of my signature.

Confirm your name and signature.

Your Name:

Lee Medical

Enter your JJIS password for Confirmation.

password:

[Elec.Sign and Save](#)

[Cancel](#)

Summary of Off-Site Care (PDF)



FLORIDA DEPARTMENT OF JUVENILE JUSTICE SUMMARY OF OFF-SITE CARE CONSULTATION REPORT

NAME OF YOUTH: Youth Name DJJID#: DJJ ID
Facility Name: _____ Date of Service: _____
Allergies: _____ DOB: DOB
Insurance: _____
Company Name Contract # Group ID #
Youth Medicaid #: (if applicable) _____
Off-Site Health Care Facility Name: _____
Address of Health Care Facility: _____
Telephone Number: _____
Specialty Service being Provided: _____

REASON FOR REFERRAL

SUMMARY OF YOUTH'S MEDICAL CONDITION OR COMPLAINT.
(THIS SECTION TO BE COMPLETED BY FACILITY STAFF).

MEDICAL ASSESSMENT AND DIAGNOSIS

NOTE TO PROVIDER:

Please complete this summary of care and return the form with youth to facility. Please state any additional instructions for facility staff. Be aware that youth may reside at a facility, which does not have licensed health care staff on duty. This form is an official document of the youth's health care record. A copy of this document may be retained for your records.

MEDICAL CARE AND TREATMENT SUMMARY OF MEDICATIONS AND TREATMENTS ADMINISTERED

ORDERS

PLEASE ATTACH PRESCRIPTIONS TO FORM

NOTE TO PROVIDER:

This section is for orders such as prescriptions, treatments, activity restrictions, and special observation/precautions.

1. _____
2. _____
3. _____
4. _____

Comments: _____

Were any diagnostic testing (lab, x-rays) done or ordered during this visit? ☐ Yes ☐ No

(Note: If lab values or x-ray results obtained please attach written reports with this summary).

Please list any pending laboratory testing or x-ray results below:

Laboratory Results: _____
Laboratory Name Telephone Number

Radiology reports: _____
Diagnostic Center Name Telephone Number

Did youth receive any Immunizations during this visit? ☐ Yes ☐ No

(If yes please list and if applicable provide a date for next scheduled immunization): _____

Is a follow-up visit required? ☐ Yes ☐ No

If yes:

Health Provider Name: _____

Location: _____

Date: _____ Time: _____

Physician/Health Care Provider Signature

Date

If you have any questions or problems using the OHS Electronic Medical Records, please contact your local Data Integrity Officer (DIO)