MARYLAND Department of Juvenile Services

Successful Youth • Strong Leaders • Safer Communities

POLICY

SUBJECT: Admission Health Screening, Nursing Assessment, and Physical Examination
NUMBER: HC-312-18
APPLICABLE TO: Somatic Health and Residential Staff

APPROVED: /s/ signature on original
Sam Abed, Secretary
DATE: 5/18/18

I. POLICY

All youth, including intrasystem and intersystem transfers, receive an admission health screen, nursing assessment and physical examination that commence at admission and are completed within fourteen (14) calendar days of admission.

II. AUTHORITY

A. Md. Code Ann., Human Services, §9-203 and §9-204.
B. American Correctional Association (ACA) Standards, 4-JCF-4C-01, 4-JCF-4C-02 4-JCF-4C-03, 4-JCF-4C-04, 4-JCF-4C-20, and 4-JCF-4C-49

III. DIRECTIVES/POLICIES RESCINDED

None

IV. FAILURE TO COMPLY

Failure to comply with the Department's Policy and Procedures shall be grounds for disciplinary action up to and including termination of employment.

V. STANDARD OPERATING PROCEDURES

Standard operating procedures have been developed.

VI. REVISION HISTORY

DESCRIPTION OF REVISION	DATE OF REVISION
New policy issued.	5/18/18
Youth Admission Questionnaire revised (Appendix 1)	3/6/20
Youth Admission Questionnaire revised (Appendix 1)	4/13/20

MARYLAND Department of Juvenile Services

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PROCEDURES

SUBJECT: Admission Health Screening, Nursing Assessment, and Physical Examination
NUMBER: HC-312-18
APPLICABLE TO: Somatic Health and Residential Staff

APPROVED: /s/ signature on original
Linda McWilliams, Deputy Secretary
DATE: 5/17/18

I. PURPOSE

To provide procedures to ensure that youth, including intrasystem and intersystem transfers, receive an admission health screen, nursing assessment and physical examination that commence at admission and are completed within fourteen (14) calendar days of admission to a facility.

II. DEFINITIONS

Facility Initial Reception/Referral Screening Tool (FIRRST) means an approved screening instrument used by an admission's officer to screen a youth before facility admittance.

Health Care Practitioner means clinicians trained to diagnose and treat patients to include, physicians, dentists, psychologists, podiatrists, optometrists, nurse practitioners and physician assistants.

Health Trained Staff are staff designated to serve as an admission's officer who are trained by a health care professional and/or a qualified behavioral health professional and appropriately supervised to carry out specific duties such as conducting youth screenings at admissions.

Health Care Professional means staff who perform clinical duties to include, health care practitioners, nurses, social workers, dietitians, emergency medical technicians in accordance with each health care professional's scope of training and applicable licensing, certification, and regulatory requirements.

III. PROCEDURES

A. GENERAL

1. The Admission's Officer shall administer the **Youth Admission Questionnaire (Appendix 1)** and the **Facility Initial Reception Referral Screening Tool (FIRRST) (Appendix 2)** to determine if the youth has any emergency medical, mental health or substance abuse conditions that would render admission unsafe. The nurse is notified and shall evaluate the youth and assist in making this determination using the **Pre-Admission Medical Assessment Form (Appendix 3)**. If a youth **screens positive on the Youth Admission Questionnaire, FIRRST or the Pre-Admission Medical Assessment Form** and is in need of emergency care, admission shall be denied. In such circumstances, the youth **shall not** be admitted until after receiving written notice of medical care provided by a health care practitioner.
2. Once a youth is accepted, the **Admission Health Screening and Nursing Assessment (Appendix 4)** and physical examination process is started with a nurse.
3. All health care encounters shall be conducted in a setting that respects the youth's privacy.
4. A female staff shall escort a female youth to private health care encounters with a male health care provider.
5. The Medical Director in cooperation with the Health Administrator and Superintendent shall establish written procedures and health screening protocols.
6. The Medical Director and/or Health Administrator shall approve all health care forms used at DJS facilities.

B. ADMISSION NURSING ASSESSMENT

1. Admission nursing assessment, physical examination, and admission diagnostic testing (laboratory testing, Tuberculosis screenings, etc.) shall commence upon the youth's arrival at the facility and shall be completed within fourteen (14) calendar days. In the absence of a nurse, the admission nursing assessment and admission diagnostic testing shall be completed the next time a nurse is on duty.
2. All findings are recorded by the nurse on the **Admission Health Screening and Nursing Assessment (Appendix 4)**.
3. The nurse shall enter the youth's name, date of birth, admission date and completion date of the **Admission Health Screening and Nursing Assessment (Appendix 4)** in the Admission Health Log. The Youth Health Record shall be started at this time. The nurse shall place the Admission Nursing Assessment, DJS Face Sheet, any medical consents, FIRRST form, court order, and any other applicable documents in the youth's health record.
4. Youth identified as having a medical issue or reporting a current health problem, injury, history of a chronic health condition, or currently on

medications shall be considered a priority for receiving an admission nursing assessment and admission diagnostic testing.

5. The nurse shall inquire and review results of previous admissions to the facility by:
   a. interviewing the youth;
   b. reviewing the Admission Information Face Sheet;
   c. reviewing the FIRRST form; and
   d. obtaining youth health record files from inactive files, another DJS facility or placement (where the youth may have been previously admitted) or any other health care provider if applicable.
6. The **Admission Health Screen and Nursing Assessment (Appendix 4)** shall include but not be limited to:
   a. Inquiry into:
      1) History of chronic illnesses and serious infections or communicable diseases, including symptoms and treatment.
      2) Tuberculosis (TB) status – **TB Screening Form (Appendix 5)** shall be completed at each admission and TB testing will occur depending on the results of the TB screening. TB testing may be omitted as indicated on the TB Screening Form (Appendix 3).
      3) Obstetrical/gynecological history and current pregnancy status;
      4) Use of alcohol and other drugs, including type(s) of drugs used, mode of use, amounts used, frequency used, date or time of last use, and history of any problems that may have occurred after ceasing use (for example convulsions);
      5) Current illness and health problems, including infectious or communicable diseases;
      6) Collection of additional data to complete the medical, dental, mental health, and immunization histories;
      7) Current medication(s);
      8) Current dental problems;
      9) Other health problems designated by the Medical Director.
   b. Observation and documentation of the following:
      1) Weight, height, and vital signs to include temperature, pulse, respiration, and blood pressure;
      2) Vision Screening;
      3) General appearance and behavior, including state of consciousness, mental status, conduct, and presence of tremors or sweating;
      4) Any evidence of abuse or trauma;
      5) Body deformities and ease of movement;

6) Condition of the skin, including trauma markings, bruises, lesions, jaundice, rashes and infestations, recent tattoos, and needle marks or other indications of drug abuse;

c. Laboratory testing and other diagnostic testing as needed

d. Medical disposition of the youth:
   1) Cleared for general population.
   2) Cleared with general population with referrals as needed to appropriate health care services.
   3) Admitted to the facility infirmary.
   4) Referred to appropriate health care service for emergency treatment; Note*: When youth are referred for emergency treatment, their admission or return to the facility is predicated on written medical clearance from the treating health care practitioner*.
   5) Scheduled for physical examination.

7. The nurse shall immediately contact the physician or nurse practitioner (MD/NP) for consultation on youth admitted to the facility who are receiving medications, special treatments or who have immediate health needs. The nurse or other health care professional shall obtain verification of medications, treatments, and health status from the youth's parent/guardian/custodian and/or the health provider who initiated the medication or treatment and shall provide this information to the MD/NP to ensure a continuum of care.

8. Youth who require close observation and/or separation from the general population because of their health status shall be maintained in the infirmary, if available at that facility. The nurse shall obtain a MD/NP order for all youth who are admitted to the infirmary for health reasons. If no infirmary beds are available in the facility, the Nurse Supervisor/Nurse Manager or Director of Nursing shall be notified by the nurse for possible transfer to an appropriate facility.

C. PHYSICAL EXAMINATION

1. All youth shall be scheduled for a **History and Physical Examination (Appendix 6)** that shall be completed within fourteen (14) calendar days upon admission to a facility, this includes intrasystem and intersystem transfers from other facilities.
   a. Youth with a chronic illness or immediate/urgent medical needs shall be triaged and scheduled for the physician's clinic the next time clinic is held.
   b. If a youth has been in one continuous facility placement, without discharge or transfer, the physical examination shall be repeated annually.

2. The history and physical examination shall be completed by the MD/NP and shall include at least the following:

a. Review of the earlier admission screening results, nursing assessment data, previous medical examinations, testing, past and current health problems, and complete review of systems;
b. Physical examination, including mental and dental status;
c. Request for any additional data to complete the medical, dental, mental health, and immunization histories;
d. Orders for laboratory and/or diagnostic tests to detect communicable diseases, including sexually transmitted infections and tuberculosis;
e. Other tests and examinations, as appropriate;
f. Orders for initiation of medications and other therapy as appropriate;
g. Development and implementation of a treatment plan, including recommendations concerning housing and program participation;
h. Sign off on the **Admission Health Screen and Nursing Assessment (Appendix 4);**
i. Referral to appropriate health care services as indicated; and
j. Orders for medical adaptive devices as medically necessary.

3. If a youth refuses to allow the admission nursing assessment, admission diagnostic testing, or physical examination to be completed, the following procedures shall be implemented by the health care professional:
   a. explain to the youth the importance of the admission assessment and/or testing;
   b. if the youth continues to refuse attempts to complete the admission assessment/testing, cease further attempts;
   c. advise the Nursing Supervisor of the youth's refusal immediately; and
   d. complete documentation along with the **Refusal of Treatment Form (Appendix 7)** and place it in the youth's health record.

IV. RESPONSIBILITY

The Medical Director and Health Administrator are responsible for implementation and compliance with this procedure.

V. INTERPRETATION

The Deputy Secretary for Operations and Medical Director shall be responsible for interpreting and granting any exceptions to these procedures.

VI. LOCAL OPERATING PROCEDURES REQUIRED

No

VII. DIRECTIVES/POLICIES REFERENCED

No policies referenced.

VIII. APPENDICES

1. Youth Admission Questionnaire
2. First Initial Reception/Referral Screening Tool
3. Pre-Admission Medical Assessment Form
4. Admission Health Screen and Nursing Assessment
5. TB Screening Form
6. History and Physical Examination
7. Refusal of Treatment Form

MARYLAND Department of Juvenile Services

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DJS POLICY AND STANDARD OPERATING PROCEDURES

Statement of Receipt and Acknowledgment of Review and Understanding

SUBJECT: Admission Health Screening, Nursing Assessment and Physical Examination
NUMBER: HC-312-18
APPLICABLE TO: Somatic Health and Residential Staff

I have received and reviewed a copy (electronic or paper) of the above titled policy and procedures. I understand the contents of the policy and procedures.

I understand that failure to sign this acknowledgment form within five working days of receipt of the policy shall be grounds for disciplinary action up to and including termination of employment.

I understand that I will be held accountable for implementing this policy even if I fail to sign this acknowledgment form.

_____	_____
SIGNATURE	PRINT FULL NAME
_____	_____
DATE	WORK LOCATION

SEND THE ORIGINAL, SIGNED COPY TO THE DIRECTOR OF THE DJS OFFICE OF HUMAN RESOURCES FOR PLACEMENT IN YOUR PERSONNEL FILE.

Maryland
DEPARTMENT OF
JUVENILE SERVICES

Youth Admission Questionnaire for Infectious Disease Risk

Name of Youth: _____Date of Birth: _____

Date of Admission: _____Time:_____ Facility:_____

This form must be completed by admission staff immediately upon arrival of each youth to the facility and before completion of the FIRRST form.

Ask the following questions and check off *Yes* or *No* or ? (if an answer is unknown):

QUESTIONS	Yes	No	?
1. Have you had a fever in the past 7 days? (Fever may be subjective or temperature 100 degrees or above)	❑	❑	❑
2. **In the past 7 days, have you had any of the following new or worsening symptoms: ❑chills, ❑cough, ❑problems breathing, ❑sore throat, ❑vomiting, ❑diarrhea, ❑loss of taste or smell, ❑rash, ❑other flu-like symptoms?**	❑	❑	❑
3. Do you feel sick now?	❑	❑	❑
4. **Have you been outside of the State of Maryland in the past 14 days?** If yes, where? _____	❑	❑	❑
5. **Have you been diagnosed with Coronavirus (COVID-19) or influenza (the flu) in the past 14 days?**	❑	❑	❑
6. In the past 14 days, have you had close contact* to someone with Coronavirus?	❑	❑	❑
7. Are you coming from a home, or another facility or program under quarantine for Coronavirus?	❑	❑	❑
8. **Is your temperature 100 degrees or above right now?** Check youth's temperature. Record temperature check here: _____ Temperature done by: ❑Forehead scanner ❑Oral/Mouth thermometer ❑Ear thermometer	❑	❑	❑
9. Does the youth appear ill?	❑	❑	❑

*Close contact would include having physical contact with or being within 6 feet for more than 2-3 minutes with someone with COVID19 while not wearing a mask

If the answer to <u>any</u> of the above questions is yes, then

- The youth may need further medical evaluation before being admitted to the facility;
- The youth shall <u>not</u> be placed in the general population but shall remain in the admission area and shall be separated from other people by a distance of at least 6 feet until further assessed by medical staff;
- Nursing staff shall be notified as soon as possible to see the youth - if nursing staff is not available on site, call the facility nursing supervisor on-call for further direction; and
- General guidelines for infection control and the disposal of contaminated articles shall be followed.

In addition to the above:

- If the youth has a temperature 100 or above or a significant cough, youth shall be given a surgical/procedural mask to wear until seen by medical.

For further questions, call Keva Jackson (DJS Health Administrator) at 410-230-3256 or Dr. Maehr (DJS Medical Director) at 410-262-0623.

Name of Nurse Notified (if needed):_____ Time notified:_____

Signature of Admission Staff: _____Date: _____Time:_____

MARYLAND DEPARTMENT OF JUVENILE SERVICES
FACILITY INITIAL RECEPTION/REFERRAL SCREENING TOOL (FIRRST)
HEALTH CARE

This form shall be used at the time of a youth's initial arrival to a DJS facility. It provides information that will determine, by observation and questioning, whether the Department will officially admit a youth to a facility or because of a need for emergency health care instruct an escorting officer to transport a youth to a hospital. The Department shall deny admittance of a youth who is unconscious, semiconscious, bleeding, mentally unstable or otherwise urgently in need of medical attention and shall instruct a transporting officer to transport a youth for immediate hospital care. A youth referred to a hospital shall have a written medical clearance prior to an admission or return to a DJS facility. **If an answer is yes to any Observations or Questions 1 through 6 below, a youth may not be admitted to a facility but transported to a hospital for emergent care.**

Youth Name _____ Admission Date _____

	No	Yes	Describe
Observations			
1. Is the youth unconscious?	___	___	_____
2. Does youth have any obvious injury(ies)?	___	___	_____
3. Does youth appear to be under the influence of alcohol/drugs?	___		_____
4. Does youth exhibit visible signs of alcohol and/or drug withdrawal (e.g. profuse sweating, vomiting, shakes, doubled over with cramps)?	___	___	_____
5. Does youth exhibit bizarre or unusual behavior (e.g. confused, incoherent or violent)?	___	___	_____
6 Do you, an arresting and/or transporting officer have information (e.g. from observed behavior) that indicates a youth is a medical, mental health or suicide risk **now?**	___	___	_____
Questions			
1. Are you thinking of hurting and/or killing yourself **now?**	___	___	_____
2. Are you bleeding?	___	___	_____
3. Do you have a serious injury (e.g. severe sprains, fractures, open wounds)?		___	_____
4. Do you currently have a communicable disease? (e.g. Mumps, Chickenpox, Tuberculosis/active TB)?	___	___	_____
5. Do you have a serious dental problem (e.g. severe pain, gum swelling, abscessed tooth)?	___	___	_____
6. Are you thinking of hurting and/or killing anyone **now?**	___	___	_____

If yes to question #6, admit youth and place under close observation and refer to clinical for assessment.

Reception/Referral

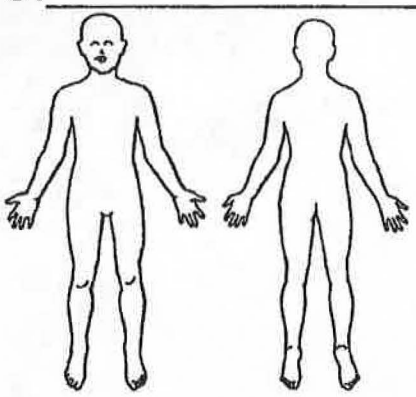
_____ Admitted to Facility _____ Referred for Emergent Care

_____ Admitted for Observation and Evaluation by clinical staff

Examiner Signature _____ Date/Time completed _____

Department of Juvenile Services
Pre-Admission Medical Assessment Form
(Complete this form if youth flags on the FIRRST Form)

Assessment Date: _____ **Time:** _____
Youth Name: _____ **DOB:** _____
Youth Complaint:
S: _____
_____
_____
_____ **Pain scale (1-10):** _____
O: _____



A: _____
_____
_____
_____
P: _____
_____
_____
(If abuse suspected or alleged, call CPS per DJS protocol)

Nursing Supervisor Notified: _____
Date and time of RN Notification: _____
MD Notified: _____
Date and time of MD Notification: _____
☐ **Denied Admission until Medically Cleared**
☐ **Accepted for Admission to Facility**

RN Name (Printed): _____
RN Signature: _____

MARYLAND Department of Juvenile Services
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ADMISSION HEALTH SCREENING AND NURSING ASSESSMENT

Name: _____ **DOB:**_____ **Current Age:** _____
(Last, First, MI)
Date of Admission: _____ **Time:** _____ **Facility:** _____

Sex (Biological): ☐Male ☐Female **Place of Birth:**_____ **Hispanic/Latino:** ☐NO ☐YES
Primary language spoken: ☐English ☐Spanish ☐Other:_____ ☐Needs Interpreter

Race: ☐Black or African American ☐White ☐Asian ☐American Indian or Alaska Native
☐Native Hawaiian or Pacific Islander ☐Other: _____
Color of Hair:_____ **Color of Eyes:**_____

Read the following statement to the youth and check that done: *"I want you to know that if you report to me or to any DJS staff person that you have been physically or sexually abused, neglected, or sexually assaulted before the age of 18, then we will need to report the incident to child protective services."* ☐**Statement read to youth, RN initials:**_____

CURRENT HEALTH STATUS

VITAL SIGNS: Temperature_____ Pulse_____ Resp _____ BP_____/_____ Wt_____ Ht_____ BMI_____
(Update/Complete Growth Charts)

Vision Screen	**Left Eye**	**Right Eye**	**Both Eyes**	***Record Vision Screen & Vitals on Admission Physical Exam form. Triage optometry referral if vision 20/40 or worse or if other vision problem.***
Without glasses:	/	/	/	
With glasses/contacts on:	/	/	/	
Has youth been given glasses or corrective contact lenses in the past? ☐NO ☐YES If yes: When & where prescribed, & location & condition of glasses/lenses:				

CHIEF COMPLAINT: Does youth have any current health complaints? ☐NO ☐YES, Specify:

PAIN: Does the youth have any pain? ☐NO ☐YES, If yes, rate pain on scale of 0 to 10:_____
Specify and describe pain:

CURRENT MEDICATION/SUPPLEMENTS: Is youth prescribed or taking any medication? ☐No ☐Yes:					
Medication Name	**Dosage**	**Frequency**	**Reason for Med**	**Prescriber**	**Last Taken**

ADMISSION HEALTH SCREENING AND NURSING ASSESSMENT

ALLERGIES: Check off below		**Specify What Allergic to:**	**Reaction to Allergen:**
	No allergies		
	Latex allergy		
	Medication Allergy		
	Insect Allergy (bee, wasp, ant, etc)		
	Food Allergy		
	Environmental (dust, mold, etc)		
	Seasonal (pollen, grass, etc)		
	Other Allergy (cat, dog, etc)		

Ever Used or Prescribed an Epi-Pen before: ☐No ☐Yes/Specify:

CHRONIC HEALTH CONDITIONS: Does the youth have any chronic health conditions? ☐No ☐Yes:

	Asthma		Eczema/Skin Problem		Seizure Disorder
	Autoimmune Disorder (e.g. Lupus)		Heart Disease		Sickle Cell Anemia or Trait
	Cancer		Hypertension (High Blood Pressure)		Stomach/Intestinal Problem
	Clotting/Bleeding Disorder		HIV/Immune Deficiency		Thyroid Disorder
	Cystic Fibrosis		Kidney/Urologic Disorder		Other:
	Diabetes		Liver Disease or Hepatitis B or C		Other:

Doctors/Specialists taking care of conditions above:

Primary Care Doctor/Provider (if known):

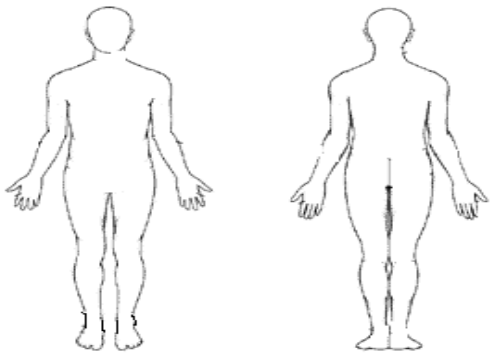
Additional Comments:

SKIN/BODY EXAMINATION: Check off below

	Acne		Dry skin		Piercing(s)
	Alopecia (hair loss)		Erythema (redness)		Rash
	Bites (animal, human, insect)		Excoriations (scratches)		Scar
	Blisters		Hives		Sutures/staples
	Boils/pustules		Jaundice		Swelling
	Bruises		Laceration/wound		Tattoo
	Burns		Lice		Warts
	Casts/splints		Nail problem		Other:
	Draining sores		Needle/track marks		Other:

DESCRIBE & Document Location of Physical Findings Above on Body Chart Below:

1. Bruise 2. Tattoo 3. Laceration/Wound 4. Scar 5. Rash 6. Piercing 7. Other (specify)



MARYLAND Department of Juvenile Services
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ADMISSION HEALTH SCREENING AND NURSING ASSESSMENT

APPEARANCE & MENTAL STATUS: Check off how the youth appears

Oriented to: ☐Person ☐Place ☐Time ☐Appears intoxicated or under the influence of drugs or alcohol

☐Alert ☐Tired/sleepy ☐Lethargic/difficult to arouse or awaken

☐Well-nourished ☐Pale ☐Underweight ☐Overweight

☐Poor hygiene ☐Disheveled ☐Sweating ☐Visible tremors

☐Cooperative ☐Uncooperative ☐Confused/difficulty answering & understanding questions

☐Calm ☐Agitated ☐Depressed ☐Withdrawn ☐Anxious

☐Other, specify:

PSYCHOSOCIAL HISTORY

Prior to admission residing with: _____ Last time home: _____
Ever homeless or runaway? ☐No ☐Yes: If yes, specify when and where_____
Parent/Guardian Name(s) & Telephone Number(s):_____
Siblings: # Brothers_____ # Sisters_____
Does youth have any children: ☐No ☐Yes: Specify DOB, sex, location: _____
Any parent, sibling, or child deceased? ☐No ☐Yes: Specify who, age, how died: _____
Any family member in DJS or jail? ☐No ☐Yes (Specify): _____
Last School Attended: _____ Last Grade Completed: _____
History of Learning Disability or Special Education Classes: ☐No ☐Yes: _____
Youth employed: ☐No ☐Yes (Specify): Sports Activities:

Previous Placements or Detention: ☐No ☐Yes: Check off below with # of times admitted and dates

	DJS Facility		**Other**
	Alfred D Noyes		Adult Detention Center/Jail (specify):
	Baltimore City Juvenile Justice Center		
	Carter		Youth Detention Center (YDC), Baltimore DOC
	Cheltenham		
	Hickey		Youth Services Center (YSC), Wash DC
	Lower Eastern Shore		
	Victor Cullen		Group Home:
	Waxter		Out of State:
	Western Maryland		Residential Treatment Center:
	Youth Centers/Allegany County*		Other:

*Backbone, Green Ridge, Meadow Mountain, Savage Mountain

MENTAL HEALTH HISTORY *(Contact Behavioral Health Staff if youth currently having suicidal/homicidal ideation)*
Prior Psychiatric Hospitalization/Placements/In-patient Evaluations: ☐No ☐Yes (Specify where, when):

Diagnosed Mental Health Illness: ☐Anxiety ☐ADHD ☐Depression ☐OCD ☐Disruptive Mood Dysregulation Disorder ☐Intermittent Explosive Disorder ☐Bipolar/Other Mood Disorder ☐PTSD ☐Other:
History of Suicidal Ideation/Gestures/Attempts: ☐No ☐Yes (Specify):
Ask: "Do you currently feel like hurting yourself or someone else?" ☐No ☐Yes (Specify):
History of Hallucinations (auditory, visual, tactile)? ☐No ☐Yes (Specify):
Ever on Psychiatric Medication? ☐No ☐Yes, Specify if not already listed on pg 1:

ADMISSION HEALTH SCREENING AND NURSING ASSESSMENT

HISTORY OF ABUSE/ASSAULT *(Being sex trafficked under the age of 18 is a form of sexual abuse and needs to be reported)*
Ever been Abused, Assaulted, or Sex Trafficked: □No □Yes: Specify □Physical □Sexual □Neglect □Mental Injury
Describe above incident(s):

If past abuse/assault, was it reported to authorities? □No □Yes: When and by whom_____
If NOT reported or not verified that reported, report to CPS per DJS policy.
NOTE: ***If a sexual assault occurred <u>in the community</u> AND youth was 18 years or older at the time of the assault, then DJS health staff must obtain informed consent from the youth before reporting the assault to an outside agency.***
Offer Mental Health Referral for past Assault/Abuse: □Accepted or □Declined by youth □NA
If accepted, Mental Health Referral requested: Date of referral request_____, RN initials:_____
If Sexual abuse/assault has occurred in the past, ensure that MD/NP has been notified within 7 days of admission.
If Sexual abuse/assault has occurred in the past 2 weeks, call MD/NP on call now for consultation: Called □Yes □No □N/A
If appropriate, offer referral to SAFE/SANE nurse. Referral made to SAFE/SANE nurse? □Yes □No □N/A

SUBSTANCE USE HISTORY				
Substance Ever Used (Check below)	**Initial Use (Age)**	**Method/Route** IV, inhaled, po, nasal	**Amount Used & Frequency**	**Last Used**
❑ Tobacco				
❑ Alcohol				
❑ Marijuana ❑ Synthetic THC				
❑ Cocaine/Crack				
❑ Amphetamines (“Meth”)				
❑ Narcotics (Oxy, Percocet, etc)				
❑ Heroin ❑ Fentanyl				
❑ Suboxone (Buprenorphine)				
❑ Methadone				
❑ Benzodiazepines (Xanax, etc)				
❑ PCP				
❑ Ecstasy				
❑ LSD/Acid				
❑ OTC cough/cold med				
❑ Other:				
Any history of drug or alcohol withdrawal in the past (e.g., convulsions or feeling sick when stop using)? □No □ Yes:				
Does youth think that he/she may experience withdrawal while at the facility? □No □ Yes:				
Any history of drug overdose or use of naloxone/Narcan? □ No □Yes:				
Any history of past substance abuse treatment as out-patient, or in-patient/residential? □No □ Yes: Any past prescribed treatment with Vivitrol, buprenorphine, or methadone? □No □ Yes:				
Additional Comments:				
Call MD if youth appears intoxicated or at risk for withdrawal/drug dependence: **Called □No □ Yes: _____**				

FAMILY HISTORY (Check off below and specify if parent, sibling, grandparent, aunt, uncle, etc)					
Condition		**Relative**	**Condition**		**Relative**
	Asthma			Hepatitis B or C	
	Cancer			HIV/AIDS	
	Diabetes			Kidney Disease/Dialysis	
	Heart Disease			Mental Health Illness:	
	High Blood Pressure			Sickle Cell Anemia	
	High Cholesterol			Drug/Alcohol Disorder	
	Stroke or Clot			Other:	
Additional Comments:					

ADMISSION HEALTH SCREENING AND NURSING ASSESSMENT

REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY

INJURIES/TRAUMA (Specify details, dates, treatment for past and current significant injuries)

	Head Injury /Concussion		Significant Lacerations/Knife Wounds
	Neck/Spine Injury		Gun-Shot Wounds
	Fractures		Retained Bullet Fragments
	Sprains/Dislocations		Elevated Lead Level/Poisoning
	Other (Specify):		No Significant Injury/Trauma in Past

Additional Comments:

INJURY PREVENTION: Review the following firearm safety tips with the youth

□ The best way to keep children safe from a gun injury is by having NO guns in a home where kids/teens live or may visit. If there is a gun in the home: □Guns should be kept UNLOADED and in a LOCKED cabinet, case, safe, or vault, and □Bullets should be stored in a separate locked location from guns.

PAST SURGERIES/HOSPITALIZATIONS (Specify below with dates, locations)

	No Surgeries		Surgeries:
	No Hospitalizations		Hospitalizations:

Additional Comments:

MUSCULOSKELETAL

	Arthritis		Joint Swelling
	Hand, Arm, or Shoulder Problem		Limitation of Movement in an Extremity or Body Part
	Foot, Leg, Hip/Pelvis Problem		Difficulty Walking
	Chest, Back, or Spine Problem		Amputation/Deformity/Prosthetic Device:
	Scoliosis/Back Brace		Any Physical Handicap:
	Other:		No Problems

Additional Comments:

EYE

	Wears eyeglasses or contacts		Eye burning or itching
	Has difficulty seeing		Eye erythema or redness on exam
	Blindness or severe vision impairment		Eye discharge on exam
	Other:		No Problems

Last Vision Exam: Date_____ Provider:_____

Additional Comments:

EARS/NOSE/THROAT

	Last Hearing Test:				Inflammation/swelling/erythema of ear
	Trouble Hearing		Deafness		Nasal congestion, difficulty breathing thru nose
	Uses Hearing Aid				Runny nose
	Tinnitus (ringing in the ear)				Hx of Frequent/Prolonged Nose Bleeds
	Ear Pain				Current epistaxis/nose bleed
	Ear drainage				Sore Throat
	Foreign body in ear or wax occluding ear				Obstructive Sleep Apnea/CPAP machine
	Other:				No Problems

Additional Comments:

ADMISSION HEALTH SCREENING AND NURSING ASSESSMENT

ORAL/DENTAL			
	Last Dental Exam:		Breath: ❑ Normal ❑ Fruity ❑ Halitosis
	Braces/Retainer – Orthodontist:		Teeth: ❑ Broken ❑ Loose ❑ Caries ❑ Missing
	Has Dentures/Dental Appliance		
	Other:		Gums : ❑ Moist ❑ Pale ❑ Swollen ❑ Bleeding
❑ ***Review importance of brushing teeth twice per day***			No Problems
Additional Comments:			

GI/NUTRITION			
	Stomach/Gallbladder Problem		Nausea
	Bowel Disease		Vomiting
	Recent Weight Loss or Weight Gain:		Diarrhea
	Eating Disorder (Anorexia, Bulimia, Pica)		Constipation
	Hx of Anemia, or Iron or Vitamin Deficiency:		Blood in Stool
	On a Special Diet:		Encopresis (leaking stool)
	Other:		No Problems
Additional Comments:			

GU/KIDNEY			
	Urinary Frequency or Urgency		Kidney Disease/Stones/Dialysis:
	Burning/Pain on Urination		Genital/Vaginal Itching or Discharge
	History of UTI		Blood in Urine
	Enuresis (bed wetting)		Urine Color: Clear - Yellow - Brown - Red - Cloudy
	Other:		No Problems
Additional Comments:			

RESPIRATORY/CARDIOVASCULAR			
	Asthma: *If yes, Complete DJS Asthma Assessment Tool*		History of Pneumonia
	Chronic Cough		History of Heart Murmur or Palpitations
	Shortness of breath		Wheezing
	Chest pain		Coughing during assessment
	Breast problem (pain, mass, discharge):		Blood tinged sputum
	Other:		No Problems
Additional Comments:			

NEUROLOGIC			
	Dizziness/Vertigo		Tics
	History of Fainting		Tingling/numbness/paralysis
	Frequent/Chronic Headaches		History of Tremors/Convulsions
	Migraines		Weakness
	Other:		No Problems
Additional Comments:			

INFECTIOUS DISEASE HISTORY (Specify details, dates, treatment of past /current infections): "Have you ever had…?"			
	Chicken Pox/Shingles		Meningitis (brain infection)
	Lice		Mononucleosis
	Lyme Disease		Scabies
	MRSA		Tuberculosis *(Complete DJS TB Screening Form on all youth)*
	Measles, Mumps, or Rubella		Viral Hepatitis A, B, or C
	Other (Specify):		No Problems
Additional Comments:			

ADMISSION HEALTH SCREENING AND NURSING ASSESSMENT

MALE REPRODUCTIVE HEALTH ASSESSMENT (Delete Page 8 if using this page)
Do you perform testicular self-exams? ☐No ☐Yes ☐*Reviewed importance of monthly self-exam w/youth*
Do you have: ☐ An undescended testicle (does youth have one or two testicles in scrotum)? ☐ A testicular, scrotal, or genital lump or mass? ☐ Other testicular or scrotal problems or concerns?
Have you ever had ☐Oral, ☐Vaginal, or ☐Anal sex? ☐No to all ☐Yes: If yes, complete this section # Sexual Partners in lifetime: ☐Female #_____ ☐Male #____ Do you currently have any sexual partners that are pregnant with your baby? ☐No ☐Yes: Age at first sexual intercourse?_____ When was last sexual intercourse?_____ Was condom used at last sexual intercourse? ☐No ☐Yes ☐Yes, but condom broke How often are condoms used? ☐Never ☐Sometimes ☐Always
☐ *Encourage/discuss consistent use of condoms to prevent sexually transmitted infection (STI) and unplanned pregnancy. Let youth know that we can provide condoms upon discharge or home pass.*
Self identifies as: ☐Male ☐Female ☐Heterosexual ☐Gay ☐Bisexual ☐Transgender ☐Intersex ☐Questioning ☐Lesbian ☐Other: Any history of hormone therapy/surgery for gender change: ☐No ☐Yes: Specify where/when/what
Have you ever had sex in exchange for: ☐Drugs ☐Money ☐Gang Initiation ☐Basic Survival/Other: Have you ever been forced to have sex? ☐No ☐Yes:
Ever had a STI? ☐No ☐Yes: ☐Chlamydia ☐Gonorrhea ☐Herpes ☐Syphilis ☐Trichomonas ☐HPV/Warts Date(s) of above:_____ Treated?_____
Are you worried you may have a STI? ☐No ☐Yes: Why?_____ Any current STI symptoms like penile sores, discharge, bumps, scrotal pain, burning, bleeding, or sore throat? ☐No ☐Yes (Specify):
Ever been tested for HIV? ☐No ☐Yes: Date_____ Result_____ *If high risk for HIV or not HIV tested in past 6 months with documented results, go over the* DJS Informed Consent & Pre-Test Information for the HIV Test *form with youth* (*unless already known HIV +).* *If youth does not fall in category above, still ask if youth wants an HIV test and if does, then complete the* DJS Informed Consent & Pre-Test Information for the HIV Test *form and perform HIV testing.*
If any lab results come back after you leave the facility, what is the best phone number to reach you? Phone number: _____ ☐Cell or ☐Home Specify who phone belongs to:

ADMISSION HEALTH SCREENING AND NURSING ASSESSMENT

FEMALE REPRODUCTIVE HEALTH ASSESSMENT (Delete Page 7 if using this page)

Age at first period _____ Date of last period_____ How long do periods last_____
Days between periods_____ Are they regular? ☐Yes ☐No: Explain_____
Pain, cramps, or heavy flow with periods? ☐No ☐Yes: Describe_____

Are you currently on a form of hormonal birth control? ☐No ☐Yes
If yes, type of birth control? ☐Pills ☐Depo/Shot ☐Implant ☐IUD ☐Patch ☐Ring ☐Other_____
Last taken or when placed?_____ Have you been using it regularly? ☐Yes ☐No:

History of Pelvic Exam in past: ☐No ☐Yes: Results_____ ☐Don't know

Have you ever had ☐Oral, ☐Vaginal, or ☐Anal sex? ☐No to all ☐Yes: If yes, complete this section
Sexual Partners in lifetime: ☐Male #____ ☐Female #_____
Age at first sexual intercourse?_____ When was last sexual intercourse?_____
Was condom used at last sexual intercourse? ☐No ☐Yes ☐Yes, but condom broke
How often are condoms used? ☐Never ☐Sometimes ☐Always

☐ *Encourage/discuss consistent use of condoms to prevent sexually transmitted infection (STI) and unplanned pregnancy. Let youth know that we can provide condoms upon discharge or home pass.*

Self identifies as: ☐Female ☐Male ☐Heterosexual ☐Lesbian ☐Gay ☐Bisexual ☐Transgender ☐Intersex ☐Questioning ☐Other: ☐History of hormone therapy/surgery for gender change:

Have you ever had sex in exchange for: ☐Drugs ☐Money ☐Gang Initiation ☐Basic Survival/Other
Have you ever been forced to have sex? ☐No ☐Yes:

Are you pregnant or worried that you might be pregnant? ☐No ☐Yes: Why?
Have you ever been pregnant? ☐No ☐Yes: OB/GYN provider:
Number of: Pregnancies_____ Live births_____ Miscarriages_____ Abortions_____
If youth pregnant, perform prenatal labs, follow prenatal guidelines, & call MD/NP/Midwife for further orders

If youth reports that she has had sexual intercourse in the past 120 hours/5 days, then discuss Emergency Contraception (Plan B) using the "EC Fact Sheet" as a guide. If youth is interested in EC, proceed to the "Emergency Contraception Protocol" to offer EC as appropriate.
☐Not necessary/No sex in past 5 days ☐Youth not interested in EC at this time
☐Youth interested in Emergency Contraception - EC Protocol Initiated

Ever had a STI or PID (Pelvic inflammatory disease)? ☐No ☐Yes: ☐Chlamydia ☐Gonorrhea ☐Herpes ☐Syphilis ☐Trichomonas ☐HPV/Warts ☐PID ☐Other:
Date(s) of above:_____ Treated?_____

Are you worried you may have a STI? ☐No ☐Yes: Why?_____
Any STI symptoms now like vaginal sores, discharge, fishy odor, bumps, pelvic/rectal/vaginal pain, abnormal menstrual bleeding, or sore throat? ☐No ☐Yes (Specify):

Ever been tested for HIV? ☐No ☐Yes: Date_____ Result_____
If high risk for HIV or not HIV tested in past 6 months with documented results, go over the DJS Informed Consent & Pre-Test Information for the HIV Test *form with youth* (*unless already known HIV +).*
If youth does not fall in category above, still ask if youth wants an HIV test and if does, then complete the DJS Informed Consent & Pre-Test Information for the HIV Test *form and perform HIV testing.*

If any lab results come back after you leave the facility, what is the best phone number to reach you?
Telephone Number:_____ ☐Cell or ☐Home
Specify who phone belongs to:

MARYLAND Department of Juvenile Services
Successful Youth • Strong Leaders • Safer Communities

ADMISSION HEALTH SCREENING AND NURSING ASSESSMENT

NURSING DIAGNOSIS: Summarize Health and Psychosocial Issues and Record Nursing Impression	
1. 2. 3. 4.	
NURSING PLAN/DISPOSITION (Check off if done)	**COMMENTS** (Check off if done and add additional comments)
☐ DJS TB Screening Form Initiated	PPD placed: ☐Yes ☐No
☐ Obtain labs following the DJS Admission Lab Protocol: • Check off labs obtained, note date in lab log • Complete DJS Informed Consent & Pre-Test Information for the HIV Test form if due for HIV test, high risk, or youth wants test	☐Urine Gonorrhea/Chlamydia ☐Other: ☐Rapid Urine Pregnancy Test ☐Prenatal labs if pregnant ☐Urine Drug Screen per court or MD/NP order ☐CBC ☐RPR ☐HIV ☐MMRV if not done in past ☐Hep C AB if at risk ☐Lead level if retained bullet fragments
☐ Sick Call Procedure Explained to Youth	☐Written Sick Call Procedure Info Provided ☐Youth Sick Call Verification Signed
☐ Initiation Of Health Education (check off what reviewed)	☐Gun Safety ☐Oral Hygiene ☐Condom Use ☐HIV testing ☐Testicular Self-Exam ☐Other:
☐ Influenza vaccine offered (if flu season)	*Remember to request vaccine records*
☐ Physician/Psychiatrist Notified For Medication Orders: Note MD/NP contacted, Date/Time	MD/NP contacted Date/Time
☐ On-Call MD/NP Contacted For Consultation: Note MD/NP contacted, date/time, reason called	MD/NP contacted Date/Time Reason
☐ Scheduled For Admission History/Physical Exam	☐Vision screen and vitals recorded on PE form
☐ Referrals made (Specify to whom and why)	☐Behavioral Health ☐CPS ☐Dentist ☐Optometrist ☐Psychiatrist ☐Gyn/Midwife ☐Other:
☐ Appropriate Log Entries Made (Specify)	☐Lab log ☐GC/CT log ☐PPD log ☐Adm log ☐MD Phone log ☐Other:
☐ Medications Ordered From Pharmacy Per Physician/NP Orders	
☐ Medication Administration Forms Completed	
☐ Unit Advised Of Special Needs With Health Status Alert : Specify what alert(s) for	**Health Status Alerts for:** *Document allergies on Chart Cover and Problem List*
☐ Cleared for General Population	
☐ Admit To Infirmary for:	☐Infirmary Admission Orders Obtained
☐ Initiation of Special Needs Treatment Plan	For:
☐ Records requested from previous placement, detention center, hospital, emergency room, etc	Specify from where records requested and document in notes
☐ Referred to Emergency Room (Specify reason)	
☐ Other:	

NURSE'S SIGNATURE:_____ **Date and Time Completed** _____

PHYSICIAN'S SIGNATURE:_____ **Review Date**_____

Note: Page 7 or 8 may be deleted based on sex of youth. *Rev 4/2/18*

DJS TUBERCULOSIS SCREENING FORM FOR YOUTH

1. All youth require screening for signs and symptoms of tuberculosis upon admission to a DJS facility.

2. Youth in a DJS facility require tuberculin skin testing (TST) with a PPD during the admission nursing process except in the situations outlined in Table 1 below.

Table 1: EXCEPTIONS TO OBTAINING TST UPON ADMISSION TO DJS FACILITY
□ *In the past 6 months,* youth has a documented negative PPD and no signs or symptoms of TB, exposure to TB, or travel to or residence in a high risk area* for TB since last tested, □ Youth with a documented history of active or latent TB, □ Youth with a documented history of a positive PPD test, □ Shortage of PPD and instruction by DJS Medical Director to hold routine TST, □ Youth with a SEVERE reaction to a tuberculin skin test such as ulceration or anaphylactic shock, □ *In the past 4 weeks,* youth has had a Varicella (chicken pox or zoster) infection – if so, PPD should be deferred for 4 weeks after varicella infection resolved, OR □ *In the past 4 weeks,* youth has had immunization with a live vaccine (MMR, varicella, or Flu Mist nasal vaccine) – if so, PPD must be done either on the same day as being immunized with a live vaccine or deferred for at least 4 weeks after being immunized with a live vaccine. *High risk area for TB includes Asia (e.g. China, Korea, India), Africa, Latin America (e.g. Mexico, El Salvador), Eastern Europe and Russia

3. A PPD is considered positive for a DJS youth per Table 2 below.

TABLE 2: INTERPRETION OF TST FOR DJS YOUTH	
TST ≥ 5 mm induration is considered positive for DJS youth with:	TST ≥ 10 mm is positive
• TB suspected by clinical signs and symptoms • HIV infection • Immuno-suppression for other reasons e.g. organ transplant, taking the equivalent of ≥15 mg per day of prednisone for ≥ 1 month, or taking TNF-alpha antagonist • Fibrotic changes on chest X-ray consistent with past TB disease • Recent close contact with TB disease: For a person with a known recent exposure to TB, the follow-up skin test should be interpreted as positive if it is 5 mm or more if the previous skin test was 0 mm or unknown; if the person had a previous skin test result of 1-9 mm, then the follow-up skin test is read as positive only if it has increased by 10 mm from the previous PPD.	• In all other situations for DJS youth

References: Centers for Disease Control and Prevention. Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from the CDC. MMWR 2006;55 (No. RR-9).

4. **Past BCG vaccination does not affect evaluation or treatment of positive PPD: A youth with a history of BCG will have the skin test interpreted as per instructions in Table 2 and needs treatment if positive!**

5. After initial screening for TB and TST at admission, youth who remain at a DJS facility will be screened for TB annually including repeat TST every 12 months if no exceptions exist as listed in Table 1 above. Screening and testing will occur sooner if youth is exposed to TB or if symptoms of TB develop.

6. **Chest X-RAY and Medical Evaluation: Who needs a chest X-ray?**
   - Youth who need a chest X-ray within 72 hours and medical evaluation by clinician:
     - Newly positive PPD, asymptomatic
     - History of positive PPD with no known chest X-ray in the past, asymptomatic
   - Youth who need a chest X-ray and medical evaluation immediately:
     - History of active or latent TB and now are symptomatic for TB
     - Signs and symptoms of TB (PPD may be unknown, positive, or negative)
   - Chest X-rays require a verbal or written order from a clinical provider (MD, NP)

7. **Respiratory isolation:** Youth who need respiratory isolation until cleared by a physician include those who:
   - Have a positive PPD and chest X-ray consistent with active TB and have not received sufficient treatment
   - Have signs and symptoms consistent with TB (productive cough with fever, night sweats, chills)

DJS TUBERCULOSIS SCREENING FORM FOR YOUTH

Youth Name: _____ DOB: _____ Country of Origin: _____

History of Previous TB Testing and Treatment	**No**	**Yes**	**Where**	**Date(s)**	**Details**
Previous PPD testing (list most recent)					____mm ❑Negative ❑Positive ❑Unknown
Previous Chest X-ray (list most recent)					Result:
Previous TB diagnosis					❑Latent TB ❑Active (contagious) TB
Previous TB treatment					Medication:

Signs or Symptoms of TB in Past 6 Months	**No**	**Yes**	**Details (e.g. dates, duration, severity)**
Productive cough for 3 weeks or more			
Cough with blood in the sputum			
Unexplained severe chest pain with cough			
Fever, chills, and night sweats			
Unintentional and significant weight loss with fatigue			
Persistent night sweats			
If yes to any of the above, youth may have TB and requires evaluation by a clinician, testing for TB via PPD (if no history of a positive PPD in past) and a chest X-ray if there are significant respiratory symptoms. Call clinician for consultation if not available on site.			
Increased Risk for TB	**No**	**Yes**	**Details (e.g. dates, location)**
Known exposure to someone with active TB since last tested for TB			
Travel or residence outside the US to high risk country since last tested for TB			
High risk area for TB includes Asia (e.g. China, Korea, India), Africa, Latin America (e.g. Mexico, El Salvador), Eastern Europe and Russia** *If yes to either of the above 2 questions, then youth requires a PPD on admission (if no history of a positive PPD in the past). In addition, a person who is exposed to active TB requires another PPD test in 8-10 weeks after exposure (unless previously positive). PPD should be interpreted as per Table 2 on reverse side.* ***If travel to Africa, complete follow-up form.			
Possible immuno-suppression: HIV positive, prednisone therapy, organ transplant, etc (see other side)			
If yes to above question, PPD should be interpreted as positive if greater than or equal to 5 mm induration.			

Does youth have any contraindications (as listed below) to PPD testing at this time?	**No**	**Yes**	**Dates**
Documented history of positive PPD in past			
Known history of active (infectious) or latent tuberculosis			
Varicella (chicken pox or zoster) infection in past 4 weeks			
Vaccination with live vaccine (varicella, MMR, Flu Mist) in past 4 weeks			
Severe allergic reaction (anaphylaxis, ulceration) to PPD in past			

Assessment/Plan: check off all that apply (see reverse side for clarification)		
❑PPD needs to be placed. Date PPD placed:_____	**Lot #:_____Exp date:_____ ❑Left forearm ❑Right forearm**	**Date read: _____ Result: _____mm ❑Negative ❑Positive RN Initials:_____**
❑PPD not done due to ❑contraindication, ❑PPD shortage, or ❑not yet due – Date rescheduled if applicable:_____		
❑Chest X-ray needed at this time - Indication for CXR: (see reverse side)	Date/result of CXR:	
❑Respiratory Isolation needed at this time – Date/Indication for isolation:		
❑Clinician notified for: (specify date/time/clinician/result)		
❑Medications ordered:		

Signature, Title of Person Completing Form: _____ Date: _____
Signature of Reviewing Clinician (MD, NP): _____ Date: _____

Maryland Department of Juvenile Services
HISTORY AND PHYSICAL EXAMINATION

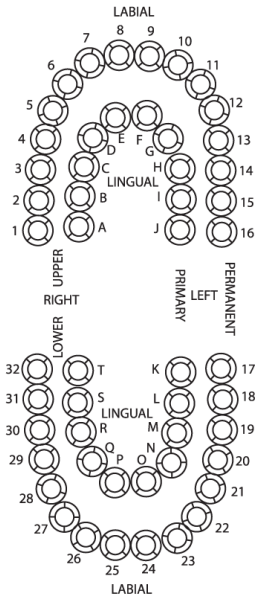
Youth's Name: _____ DOB: _____

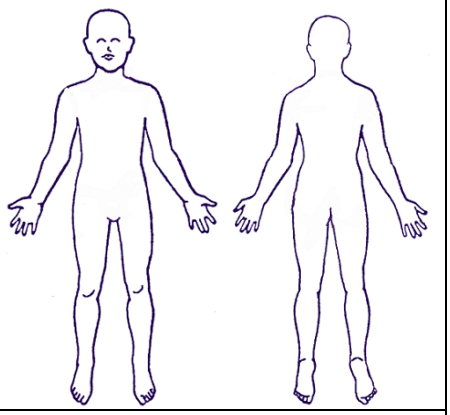
VITALS Date:_____ Initials:_____	Weight_____ (lbs) ____ (%)		Height_____ (in) ____ (%)		BMI_____ / ____%	**AUDIOLOGY TESTING** (if necessary) Freq 500 1000 2000 4000 Right Left Date done: Initials:
	Temp	Heart Rate	Resp Rate	BP	Repeat BP (If needed)	
VISION Date:_____ Initials:_____	❑Youth normally wears glasses/contacts ❑Youth wore glasses/contacts for vision screen Date/result of last vision screen if not done today: _____			Left eye 20/____	Right eye 20/____	Both eyes 20/____

PHYSICAL EXAM	✓ Check off normal findings	List Additional Comments/Abnormalities Below
General Appearance	❑NAD ❑WD ❑WN ❑Alert	
Mental Status	❑Oriented ❑Affect Normal	
Head/Scalp/Hair	❑Normocephalic ❑Atraumatic ❑No lice visible ❑No lesions/rash	
Eyes	❑PERRLA ❑EOMI ❑Sclera/conjunctiva clear	
ENT	❑Hearing grossly normal ❑TMs intact ❑Nose/nares normal ❑Oropharynx & tonsils normal	
Mouth/Teeth/Gums (Use dental diagram)	❑No lesions on lips/mouth ❑No obvious dental decay or trauma	
Neck/Thyroid	❑Supple ❑No goiter/masses ❑No meningeal signs	
Lymph nodes	❑No lymphadenopathy	
Chest/Breasts	❑Normal sternum/breasts Breast Tanner Stage (circle) 1 2 3 4 5	
Lungs	❑Breath sounds clear and equal ❑Normal respiratory effort	
Cardiovascular	❑S1/S2 ❑RRR ❑No murmur ❑Pulses equal bilaterally	
Abdomen	❑No HSM ❑No masses ❑Nontender	
GU	Pubic Hair Tanner Stage 1 2 3 4 5 Male Genitalia Tanner Stage 1 2 3 4 5 ❑Testes descended bilaterally ❑No testicular/scrotal masses ❑Circumcised ❑Uncircumcised ❑Normal female ext genitalia (if done) ❑No hernia detected	
Back/Spine	❑No CVAT ❑No scoliosis	
Musculoskeletal & Extremities	❑ROMI ❑Ambulates well ❑Moves all extremities well ❑No swelling/edema ❑Strength grossly intact	
Neurologic	❑Reflexes grossly normal ❑CNs 2-12 grossly normal	
Skin (Use body diagram if needed)	❑No rashes ❑No lacerations ❑No significant bruises/scars ❑No needle/track marks	
Nails/Palms/Soles	❑Nails normal without sign of infection ❑Palms and soles normal	
Other		
Recent Labs or Studies Reviewed		

Dental Key: Identify dental decay with ≡
Fillings or caps with ●
Cracked/chipped teeth with ‖

Identify missing teeth with "X"





Signature of Clinician completing PE: **Date completed:**

Maryland Department of Juvenile Services
HISTORY AND PHYSICAL EXAMINATION

YOUTH'S NAME:	Admission Date	DOB	Age	Sex: Gender:	LMP

Current Health Problems and Concerns:

Pain: ❑No ❑Yes: (rate on scale of 1-10 and describe above)

Chronic medical and mental health conditions (describe below): ❑None ❑Asthma ❑Diabetes ❑Seizure disorder ❑Sickle cell ❑ADHD ❑Depression/bipolar ❑Anxiety ❑Other:

Current and recent medications (including supplements and birth control):

Allergies (specify):	❑NKDA ❑Medication/vaccine ❑Food ❑Seasonal/environmental ❑Latex ❑Other	**Date & result of last PPD (if known):**
Past Medical & Psych History	❑No significant history ❑Hospitalizations: ❑Other:	
Past Surgical & Orthopedic Hx	❑No significant history ❑Surgeries: ❑Fractures/other significant ortho problems:	
PCP & Specialists		**Date & reason for last Dental Exam:**

ROS	Neg	Pos	Describe positives.	ROS	Neg	Pos	Describe positives.
General				GU/STIs			
Nutrition/Endocrine				Menstrual cycle			
Derm				Musculoskeletal			
Eyes & ENT				Heme/Onc			
Dental				Immune/Infectious			
Respiratory/Chest			❑resp distress w/exercise	Neuro/psych			❑syncope
Cardiovascular			❑murmurs ❑arrhythmias	Handicaps/disabilities			
GI				Other			

Family History (specify) ❑Negative ❑DM ❑HTN ❑Heart disease/stroke/sudden death <55 yrs ❑Hi cholesterol ❑Cancer ❑Hepatitis B, C or HIV ❑Other

Psychosocial & Sexual History Youth currently living with or at:

School issues: | Menarche: | Coitarche: | # Lifetime sexual partners: Male_____ Female_____

Any children: ❑No ❑Yes: | Any pregnancies: ❑No ❑Yes: | Any risk of pregnancy at this time: ❑No ❑Yes:

Any sign (e.g. discharge, pain, lesion) of STI at this time: ❑No ❑Yes:

Past history of STIs: | Last HIV test date/result (offer HIV testing):

Use of tobacco, alcohol, recreational and intravenous drugs:

Any risk of withdrawal from tobacco, alcohol, or drugs at this time: ❑No ❑Yes:

Any history of sexual or physical abuse/assault or neglect: ❑No ❑Yes:

Currently suicidal or at risk to self or others: ❑No ❑Yes:

ASSESSMENT/PLAN	CLEARANCE (Check off all that apply):
1. List acute/chronic health needs & treatment plan including medications: 2. Vaccinations: ❑Records not available or incomplete ❑Vaccines UTD ❑Vaccines recommended at this time: ❑Vaccines given today: 3. Additional Labs or studies ordered: 4. Nursing Assessment reviewed and signed: ❑No ❑Yes	❑Youth is cleared for ALL activities & sports ❑Youth is cleared for all activities & sports except for: ❑Youth requires further treatment or evaluation prior to clearance for: ❑Youth has no evidence of a serious communicable disease (e.g. TB, varicella, or meningitis) that may put other children at risk. **REFERRALS NEEDED** ❑Vision ❑Dental ❑ Psych ❑OB/Gyn ❑Other: **FOLLOW-UP REQUIRED:**

Clinician name	Facility	Date
Clinician signature		

MARYLAND Department of Juvenile Services
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REFUSAL OF TREATMENT FORM

Name:_____ DOB: _____ Facility: _____

Nature of Condition:
Treatment Recommendation:

I, _____ acknowledge that I have read and understand
(*Youth's Name*)

the nature of my condition and the treatment offered by the health care staff at this facility.

I refuse to accept these services as prescribed to be in my best interest.

Youth's Signature: _____ Date: _____ Time: _____

Witness Signatures:

Staff: _____ Date: _____ Time: _____

Nurse: Date: Time: