Division of Juvenile Justice Services
Office of Community Programs
Name

MEDICAL OR MENTAL HEALTH REPORT
DJJS Incident Report No.: 2014 – **[Office Use Only]**
PbS Incident ID: **[Office Use Only]**

Case #	Juvenile's Name & Gender	Date seen by Medical		
		MM	DD	YYYY
	Gender: **			

Reason for Juvenile Examination: Comments*			
☐ Medical Emergency	☐ Assault by Staff	☐ Mechanical Restraints	☐ Suicidal Behavior
☐ Accident (horseplay)	☐ Assault by Youth	☐ Physical Restraint (ICR)	☐ Self-harm
☐ Accident (other)	☐ Initiated Assault	☐ Other Restraint (helmet, etc.)	☐ Tattooing
☐ Accident (recreation)	☐ Sexual Assault	☐ Not Recorded	☐ Other
	☐ Fight		

Juvenile taken off-site for medical attention: Yes or No*

Name of Medical Staff (Print/Type) **APD Initials** **Date**

Signature of Medical Staff **Title of Medical Staff** **Date**

Save As...

Form revised 11-22-13