



# Post-Adjudication Pre-Admissions Information Form

Juvenile Name:	Probation Officer Name:	County:

If you have questions or need assistance with a physical, dental, TB test or psychological/behavioral health assessment, please call 903-786-6326 and speak with the Intake Coordinator.

<b>A court order for placement is required, the order shall state:</b>	
"Placement at the Grayson County Department of Juvenile Services until successful completion of the program or until further order of the Court." Please attach the conditions of probation.	
Phone: (903) 786-6326 Fax: (903) 786-9401 Email: burtonk@co.grayson.tx.us	
<input type="checkbox"/>	<b>Adjudication &amp; Disposition Order for Placement</b>
<input type="checkbox"/>	<b>Conditions of Probation</b> – The resident will memorize their court ordered conditions and this will aid in outlining the residents visitation, phone and mail limitations.
<input type="checkbox"/>	<b>Interagency Application for Placement (Common Application for Placement)</b>
<input type="checkbox"/>	<b>Psychological Evaluation/Behavioral Health Assessment (Completed within 12 months of admission)</b> – Should indicate appropriateness for the child's placement at the facility based on the needs and/or limitations of the child (mental illness, history of abuse, etc.) and placement in a physical training program. <i>Psychological Addendum also required.</i>
<input type="checkbox"/>	<b>Immunization Records</b>
<input type="checkbox"/>	<b>Physical Examination (Completed within last 90 days. Must be signed by a MD, DO, PA or NP)</b> – Due to the nature of the daily training and activity, this must be completed on the attached Department form (Attached). <i>"Cleared" must be circled.</i>
<input type="checkbox"/>	<b>Tuberculosis Test (Completed within 12 months of admission)</b>
<input type="checkbox"/>	<b>Medical and Medication Authorization Form</b> – Completed by Parent/Guardian
<input type="checkbox"/>	<b>Dental Exam (Completed within 180 days of admission)</b>
<input type="checkbox"/>	<b>30 Supply of Medications</b>
<input type="checkbox"/>	<b>Social Security Number</b>
<input type="checkbox"/>	<b>Birth Certificate</b>
<input type="checkbox"/>	<b>Education Records/ARD Information</b>
<input type="checkbox"/>	<b>MAYSI</b>



# Post-Adjudication Physical Evaluation Form

PHYSICAL EVALUATION  
Must be signed by MD, DO, PA or NP

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Pulse: \_\_\_\_\_

Vision: R 20/\_\_\_\_\_/\_\_\_\_\_ L 20/\_\_\_\_\_/\_\_\_\_\_ Corrected: Y \_\_\_\_\_ N \_\_\_\_\_ Pupils: \_\_\_\_\_

Immunization Reviewed & Current: Y \_\_\_\_\_ N \_\_\_\_\_ TB Test Administered (Date): \_\_\_\_\_

TB Test Read (Must be read within 48-72 hrs.) Date: \_\_\_\_\_ Time: \_\_\_\_\_ Results: Pos. \_\_\_\_\_ Neg. \_\_\_\_\_

	Normal	Abnormal Findings
Cardiopulmonary		
Heart		
Lungs		
Tanner Stage		
Skin		
Abdominal		
Genitals		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
Dental		

**Clearance: (Please Circle A of B Below) Must be signed by a Medical Doctor**

- A. **Cleared** for physically strenuous physical training (Boot Camp/Military) program participation, which will consist of daily running and various calisthenics including but not limited to: pushups, sit ups, jumping jacks, lunges.
- B. **Not Cleared** due to: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Signature of MD: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

MD's Printed Signature: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_



# Post- Adjudication Medical Screening Information

Name:	Age:	Date of Birth:
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History must be completed by resident and parent/guardian prior to physical exam. Please provide completed form at physical.

1.	Have you ever been hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever had surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Are you currently taking any medicine? If yes, please provide at least 30 day supply.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Have you ever passed out during or after exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Have you ever had chest pains during or after exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Do you tire more quickly than your friends during exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Have you ever had high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Have you ever been told that you have a heart murmur?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Have you ever had a racing heartbeat or felt like your heart skipped a beat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Has anyone in your family died of heart problems or a sudden death before age 50?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Do you have any skin problems (itches, rashes, acne?)	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Are you allergic to any food, drug, medications or stinging insect?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Have you ever had a seizure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	Have you ever had heat or muscle cramps?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Have you ever been dizzy or passed out in the heat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	Do you have trouble breathing or do you cough during or after activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18.	Do you have a history of asthma or breathing difficulties?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19.	Do you use any special equipment (pads, braces, neck rolls, mouth/eye guard)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20.	Have you ever had any problems with your eyes or vision?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21.	Do you wear glasses or special eyewear? If yes, please provide.	<input type="checkbox"/> Yes <input type="checkbox"/> No
22.	Have you sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? If yes, any current issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No
23.	Do you wear any brace or assistive device? If yes, please provide.	<input type="checkbox"/> Yes <input type="checkbox"/> No
24.	Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
25.	Have you had any medical problems or injury since your last evaluation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
26.	Do you wear orthodontics (braces, retainer, etc.)? If yes, what is plan of care while in placement?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes to any questions, please explain:

Resident Signature

Date

Parent Signature

Date

**Grayson County Department of Juvenile Services  
MEDICAL AND MEDICATION AUTHORIZATION**

I, the undersigned parent/legal guardian of \_\_\_\_\_, hereinafter referred to as "my child", do hereby authorize and extend permission to the Grayson County Department of Juvenile Services, Grayson County, it's officers, agents, and employees, hereinafter referred to as "the Facility" to authorize and provide medical and mental health care for my child.

I do hereby authorize any doctor and/or medical or mental health facility selected by the Facility to render any and all necessary medical and/or mental health services to and for my child, including but not limited to examinations, injections, surgery and isolation for any contagious disease, and individual psychotherapy.

I do hereby authorize any medical and psychiatric care, including but not limited to being seen/evaluated by a psychologist, psychiatrist, therapist and/or admittance into an in-patient psychiatric hospital.

I do hereby authorize the facility staff to administer prescription medication to my child as ordered by a physician. I understand that non-prescription medication will not be allowed unless approved by the administration of the Facility.

I do understand that any cost incurred from the doctors or the hospital in which my child is referred is my responsibility. I also understand that any cost of prescription medication my child is ordered to take is also my responsibility.

I do hereby agree to save, hold harmless and indemnify the Facility of and from any and all claims, demands and causes of action whatsoever on account of or in any way resulting from or to result from the authorizing by the Facility of any such medical services or administration of prescription medication.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Home address of Parent /Guardian

\_\_\_\_\_  
Telephone/Cell

**Insurance Information: Please provide copy of front and back of card**

Insurance Company \_\_\_\_\_

Member's name and DOB \_\_\_\_\_

Policy and Group # \_\_\_\_\_

**Medical history to be completed by parent (prior to physical)**

	Yes	No		Yes	No
Past surgical procedures			Ongoing medical problems		
Have you ever been hospitalized			Seizures		
Have an allergy to food or drugs			Bone/Joint problems		
Wear prescription glasses (must provide)			Doctor order brace/assistive device (must provide)		
Fainting or dizziness while exercising			Skin problems (rashes, acne)		
Asthma ( must provide current medication)			Significant medical problems		
Wears Orthodontia (braces)			History of head injury		

If yes to any above questions, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List current doctor prescribed medications your child is routinely taking: **Please ensure your child has a 30 day supply upon intake**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who will be responsible for providing while in custody? \_\_\_\_\_





Grayson County  
Department of Juvenile Services  
Post-Adjudication Program

**ADDENDUM TO PSYCHOLOGICAL EVALUATION**

Juvenile's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Examiner's Name: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

I understand that this juvenile will be participating in a residential program that includes a physical training component.

Based on the information available at the time of this juvenile's evaluation, there are no clear therapeutic contraindications to his participation in a physical training program.

\_\_\_\_\_  
Examiner's Signature

\_\_\_\_\_  
Date