Ada County Juvenile Court Services
Weekend Detention Program Health Screen

Name: ______________________ **Date:** ____________

Date of Birth: _______________________
Mother: ___________________________ Father: ____________________________
Mother's Home Phone: _______________ Father's Home Phone _________________
Mother's Work Phone: _______________ Father's Work Phone _________________

Emergency contact other than parents: ____

Emergency Contact Phone Numbers: (Home)_______________(Work)____________

Allergies: Bee Stings, Hay-Fever, Metals, Food, Other: _________________________
____

Are you currently taking any prescribed medications? (Name of Prescribing Doctor, Name of Prescription Medication, Dosage, Time Taken and Reason)

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____

Do you have a history of seizures? Yes ☐ No ☐
Date of last seizure activity:

____
____

Do you have a mental health diagnosis? Yes ☐ No ☐
If "yes," please provide information:

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____

Any other significant medical information that the Detention Medical Department should know: ____
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Females Only:
Are You Pregnant? Yes ☐ No ☐ Doctor's Name: _________________________
Number of Months: _______