

**Mississippi Department of Human Services  
Division of Youth Services  
Medical Services**

**Health Call Form**

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Living Unit:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**What is wrong with me:** \_\_\_\_\_

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

**Student Signature:** \_\_\_\_\_

See Interdisciplinary Progress Notes for assessment and treatment documentation.

\_\_\_\_\_  
Nurse Signature /Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time