Mississippi Department of Human Services
Division of Youth Services
Medical Services

Health Care Plan and Medical Instructions

Name: _____	**Living Unit**: _____
DOB: _____	**Start Date**: _____ **Time**: _____
	Stop Date: _____ **Time**: _____

Cause of Restriction(s): _____

DAILY ACTIVITY RESTRICTIONS

- ☐ Bed rest with bathroom use only
- ☐ Partial bed rest; may be out of bed: _____
- ☐ Diet restrictions: _____

_____ Must eat in (room/program area)
_____ Must have carry-back meal
_____ May go to cafeteria for meals
_____ May go to Medication Line or Clinic for treatments

PHYSICAL ACTIVITY RESTRICTIONS

_____ No gym activities or work details
_____ No body contact sports
_____ No outdoor activities
_____ Must use sunscreen with outdoor activities
_____ No running, jumping or calisthenics
_____ Upper _____ lower _____ weight training only
_____ Use of: crutches _____ sling _____ brace _____

Further Instructions:

Nurse's Signature: _____ Date: _____