Mississippi Division of Youth Services Medical Services			Name: DOB:Date:		
Influenza Screen					
Allergies:	,				
A 11					
Symptoms:					
	ata: □ Yes □ N	o if yes, onset/	duration	Hours	Days (Circle)
Comments: Cough: □ Yes	s □ No if ye	es, Dry Produ		uration	Hours Days
Comments:					
	es 🗆 No Com	ments:			
Comments: Lives in area	of confirmed	l case or recen	t visit to area	□ Yes □ No	
Obligativa Da	4				
Objective Da Vital Signs	ta: Temp:	Pulse:	Resp:	B/P;	Pulse Ox:
Vital Signs If the patient	Temp: thas a tempe is screen will Positive		4 or greater a	B/P: nd one of the sub	
Vital Signs If the patient identifiers the Screen:	Temp: thas a tempe is screen will Positive	rature of 100.4 be noted as po	4 or greater a		
Vital Signs If the patient identifiers the Screen:	Temp: thas a tempe is screen will Positive	rature of 100.4 be noted as po	4 or greater a		

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