Mississippi Department of Human Services - Division of Youth Services
MEDICAL RELEASE SUMMARY

Name: _____	**Institution:** Oakley Youth Development Center
DOB: _____ HT:_____ WT:_____	**Admission Date:** _____ **Release Date:** _____

Aftercare Medical Follow-up: Yes ☐ No ☐ N/A ☐	**Psychiatry Follow-up**: Yes ☐ No ☐ N/A ☐
Immediate ☐ Within 30 Days ☐ Advise Parents ☐	Immediate ☐ Within 30 Days ☐ Advise Parents ☐

Allergies: Yes ☐ No Known Allergies ☐ **Note: N/A = Not Applicable**

Allergy: _____/Symptom(s): _____

Allergy: _____/Symptom(s): _____

Current Medications: Yes ☐ No ☐ Comment: _____

Medication	Dose	Prescription	Refills	Prescription Distribution (Sent/Faxed/Given to Parent)
		Yes ☐ No ☐ N/A ☐	No ____ Refills ____	
		Yes ☐ No ☐ N/A ☐	No ____ Refills ____	
		Yes ☐ No ☐ N/A ☐	No ____ Refills ____	
		Yes ☐ No ☐ N/A ☐	No ____ Refills ____	

Parent's signature: (receipt of any Rx's and copy of this form): _____

Health Problems (history and current): Yes ☐ No ☐ _____

_____

_____

_____ Last Physical Exam Date: _____ Last Dental Exam Date: _____

_____

Medical/Dental Referral(s) Scheduled: Yes ☐ No ☐ _____

Medical/Dental Referral(s) Needed: Yes ☐ No ☐ _____

_____

_____

Immunizations: Please see attached Immunization Record

TB Skin Testing: Date: _____ Results: _____mm Chest X-Ray Date/Results (Positive PPD only): _____

Health Department Notified: Yes ☐ Date: _____ Location: _____ No ☐ N/A ☐

Vision: Visual Screen Date: _____ Screening Results: OD _____ OS _____ OU _____

Optometry Exam Date: _____ N/A ☐ Glasses: Yes ☐ No ☐ N/A ☐

Hearing: Right Ear: ☐ Pass ☐ Fail Left Ear: ☐ Pass ☐ Fail Audiologist Exam: ☐ Yes ☐ No ☐ N/A

Physical Aids: Yes ☐ List: _____ No ☐

Special Diet: Yes ☐ List: _____ No ☐

Nurse's Signature: _____ **Date:** _____