

**DENNEY JUVENILE JUSTICE CENTER
JUVENILE DETENTION SERVICES
HEALTH SERVICES
Ph 425-388-7816; Fax 425-388-7817**

MEDICATION/EQUIPMENT VERIFICATION

Dear Parent/Guardian:

The nursing staff wants to work with you to have this child get medications, equipment or other necessary care while in detention. Medications can only be given with a written or telephone order of the licensed prescriber, so please write down the prescriber's name and telephone number. Medications must be in a current prescription bottle- filled within last 30 days. The use of any medications and equipment will be evaluated by the DJJC nurse practitioner.

Date _____

Youth Name _____ **Date of Birth** _____

Person bringing medication/equipment _____

Relationship to Youth _____ Phone () _____

Medication/Equipment Name _____

Diagnosis/Reason for use _____

Current dose and times to be taken _____

Doctor _____ Phone () _____

Number of doses missed in last two weeks _____

Medication was last taken? Date _____ a.m./p.m.

Is this medication in a current prescription package? Yes _____ No _____

If no, explain _____

(Nurse) Count _____ Rx Fill Date _____

Medication/Equipment Name _____

Diagnosis/Reason for use _____

Current dose and times to be taken _____

Doctor _____ Phone () _____

Number of doses missed in last two weeks _____

Medication was last taken? Date _____ a.m./p.m.

Is this medication in a current prescription package? Yes _____ No _____

If no, explain _____

(Nurse) Count _____ Rx Fill Date _____

Insurance Provider for youth: _____

If Group Health, provide I.D.# _____

Do not have any insurance coverage Don't know if youth has insurance

I authorize Detention or Secure CRC staff to assist this youth in getting his/her prescribed medication while in this facility.

Parent/Guardian Signature _____