Sault Tribe Youth Facility

Telephone (906)643-0941 Fax (906)643-6340

MEDICAL CLEARANCE FORM

1. YOUTH'S NAME: _____ DOB: _____
2. TRANSPORTER / TRANSPORTING OFFICER: _____
3. REFERRING COURT: _____
4. DATE: _____ TIME: _____

SELECT ONE

□ *Youth has been medically cleared prior to arrival for reason(s) listed below.*

□ *I/we have declined to accept the above named youth, pending medical clearance for the following reason(s):*

□ *Unconscious* □ *Injured* □ *Bleeding* □ *Fracture(s)* □ *Pregnant*

□ *Intoxicated/Alcohol* □ *Drugs* □ *Other, explain:* _____

5. PRINTED NAME AND SIGNATURE OF DETENTION OFFICER:

_____ DATE: _____ TIME: _____

==========

THIS PORTION TO BE COMPLETED BY MEDICAL STAFF

NAME OF HOSPITAL/CLINIC AND TELEPHONE: _____

6. MEDICAL DIAGNOSIS

I have examined the youth to determine if he/she can safely be admitted to the Sault Tribe Youth Facility, based on the above listed concerns/reasons.

☐ **I FIND YOUTH ACCEPTABLE FOR ADMISSION TO THE SAULT TRIBE YOUTH FACILITY.**

☐ I do not have any specific suggestions regarding the care of this youth for the condition(s) for which I have examined him/her.

☐ I have specific suggestions/treatment regarding the care of this child for the condition for which I have examined him/her.

Medical health care provider's suggestions/treatment (attach additional instructions if necessary):

_____

_____

☐ I have examined the youth and find him/her **UNACCEPTABLE** for admission to Sault Tribe Youth Facility.

Medical health care provider's remarks: _____

7. PRINTED NAME/SIGNATURE OF EXAMINING MEDICAL HEALTH CARE PROVIDER:

_____

==========

8. Based on the medical health care provider's review and medical clearance, I/we accept the above name youth.
PRINTED NAME/SIGNATURE OF DETENTION OFFICER:

_____ DATE: _____ TIME: _____

ONCE COMPLETED BY MEDICAL STAFF PLEASE FAX TO 906-643-6340 or deliver to booking officer at Sault Tribe Youth Facility.