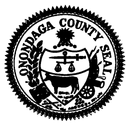


**HILLBROOK**
COUNTY OF ONONDAGA
Department of Probation

4949 Velasko Road
Syracuse, New York 13215
(315) 435-1421 Fax: (315) 435-2671
www.ongov.net


**MEDICAL AUTHORIZATION TO TREAT MUST BE PROVIDED ALONG WITH A SIGNED RELEASE OF INFORMATION BY PARENTS/GUARDIAN**

**NEED TB(PPD) SKIN TEST DOCUMENTATION –DATE PLANTED, DATE READ AND RESULTS. IF POSITIVE RESULTS, WE NEED FOLLOW-UP CONFIRMATION.**

**IF RESIDENT IS ON ANY MEDICATION OR UNDER PHYSICIAN'S CARE, THE PARENT/GUARDIAN MUST SIGN A HILLBROOK RELEASE OF INFORMATION FORM AND ALSO PROVIDE A TWO-WEEK SUPPLY OF MEDICATIONS. THIS MUST ACCOMPANY RESIDENT TO HILLBROOK.**

**PLEASE SEND ANY ADDITIONAL INFORMATION: (I.E. PSYCH EVALUATION, PROBATION REPORT)**

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**MEDICAL INFORMATION:**

Name: ______________________________________________ DOB:__________________
Recent illnesses or injuries:______________________________________________
General health issues:____________________________________________________
Current problems:_______________________________________________________
Allergies:______________________________________________________________
Physical limitations:_____________________________________________________

Check Any That Apply: ☐Bedwetting ☐Nightmares ☐Pregnant
☐Eating Disorder ☐Phobias ☐Lice ☐Scabies

List All Medications: (Complete Consent to Medicate Form for Each Medication Listed and Provided)

| Name of Medicine | Dosage | Instructions | Prescribing MD |
|---|---|---|---|
| ____________ | ________ | __________ | ______________ |
| ____________ | ________ | __________ | ______________ |
| ____________ | ________ | __________ | ______________ |
| ____________ | ________ | __________ | ______________ |

Mental Health: (Complete for Each)

| Issue | Date or N/A | Description of Event |
|---|---|---|
| Suicide Attempt | ______________ | ________________ |
| Suicide Ideation | ______________ | ________________ |
| Self-mutilation | ______________ | ________________ |
| Homicide Intent | ______________ | ________________ |
| Known Diagnoses | ______________ | ________________ |
| Recent Hospitalization | ______________ | ________________ |
| Psych Evaluation | ______________ | ________________ |