Allen County Juvenile Center

2929 Wells Street
Fort Wayne, IN 46808

OUT OF COUNTY ADMISSION FORM

COUNTY: _____ DATE: _____

JUVENILE'S FULL NAME: _____

ADDRESS: _____

D.O.B.: _____ PHONE NUMBER: _____

RACE: _____ HAIR: _____ EYES: _____ HT.: _____ WT: _____

****

MOTHER'S NAME: _____ FATHER'S NAME: _____

ADDRESS: _____ ADDRESS: _____

PHONE NUMBER: _____ PHONE NUMBER: _____

EMPLOYER: _____ EMPLOYER: _____

****

FAMILY DOCTOR: _____ PHONE NUMBER: _____

****

ADJUDICATED DELINQUENT YES ____ NO ____ DATE ADJUDICATED _____

CHARGES ADJUDICATED ON (List all)_____

_____

CURRENT CHARGES PENDING: _____

LENGTH OF ANTICIPATED STAY AT ACJC: _____

PROBATION OFFICER: _____

ADDRESS: _____ OFFICE NUMBER: _____

BRIEFLY EXPLAIN REASON FOR DETENTION: _____

ACJC OFFICIALLY CONTACTED: _____ TIME: _____

TRANSPORTING OFFICER (print): _____

2929 Wells Street * Fort Wayne, IN 46808-1599 * (260) 449-8449 * Fax (260) 449-7480

ALLEN COUNTY JUVENILE CENTER CONSENT FOR MEDICAL TREATMENT OF A MINOR CHILD & AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I (We) _____ and _____
(Parent) (Parent)

of _____, _____, _____
(City) (County) (State)

state that I am (we are) the parent(s) or legal guardian(s) of _____,
(Detained Juvenile)

a minor, age: _____ born: _____ who resides with me (us) at
(Date of Birth)

_____, _____, _____ _____
(Address) (City) (State) (Zip Code)

I (We) authorize the Allen County Juvenile Center, 2929 Wells Street, Fort Wayne, Indiana 46808, County of Allen, State of Indiana to consent to any necessary examination, vaccination, medical diagnosis, release of medical information, treatment or hospital care to be rendered to the above named minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the state of Indiana. This consent to disclose information may be revoked by me in writing at any time, except to the extent that action already has been taken. This consent (unless expressly revoked earlier) expires in one year or when the child is released from the jurisdiction of the Court, whichever first occurs.

Dated this _____ day of _____, 20_____

_____ _____
(Signature of Parent/Guardian) (Signature of Parent/Guardian)

_____ _____
(Juvenile Signature) (Witness)

Medical Insurance Carrier: _____

Identification No.: _____

Member's Name: _____

Account Number: _____

Medicaid Number: _____

Family Doctor(s): _____

_____

Medical Information:

Allergies: _____

Chronic/Existing diseases (diabetes, epilepsy, etc):

_____

Current Medication: _____

_____