San Bernardino County Probation Department
Detention Corrections Bureau
INFORMATION VERIFICATION FORM

Date: ____________

Youth's Name: ____
Last First Middle

Address: ____
City/State Telephone Number

JJIS/JPIN#: ____________________ DOB: ______________ D.O.E.: ______________

QUESTIONS	Yes	No
1. Is your child under the care of a medical doctor, psychiatrist, or psychologist? Name: Phone Number:		
2. Does your child have medical insurance? Name and Policy #:		
3. Is your child taking medication? Name/Dosage:		
4. Does your child have any injuries or illnesses? List:		
5. Does your child have any mental health or emotional problems? List:		
6. Has your child ever attempted suicide? Date:		
7. Has your child ever been hospitalized for a psychiatric issue? Date: Hospital:		
8. Does your child have a history of communicable diseases such as chicken pox, measles, STD or TB? List:		
9. Does your child use street drugs or alcohol? Type/Frequency:		
10. Does your child smoke cigarettes?		
11. Does your child have a bed-wetting problem?		
12. Does your child have any food restrictions/allergies? List:		
13. Does your child have any physical limitations or disabilities? List:		
14. Is your child a special education student or have an IEP?		
15. Has your child been sexually abused/assaulted within the past 72 hours? Reported: Yes☐ No☐ (list date reported and agency information in additional comments)		
16. Has your child ever been physically or sexually abused? Reported: Yes☐ No☐ Date reported:		
17. Is your child's gender expression different from their birth gender?		
Additional Comments:		

1st Attempt
Completed? Yes ☐ No ☐ Date/Time: ______________ By: ______________________
(attempted or completed) Print/ Sign Name

2nd Attempt:
Completed? Yes ☐ No ☐ Date/Time: ______________ By: ______________________
(attempted or completed) Print/Sign Name

Name of Person Contacted: ______________________ Relationship: ______________

Reason for Non-Contact: ____

FORM COMPLETED/ENTERED INTO CE BY: ______________________ ____________
Print/ Sign Name Date/Time

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REVIEWING PHYSICIANS SIGNATURE: ______________________ ____________
Date/Time

Upon completion copy and distribute:
Original: Youth's Facility File, 1st Copy: Medical Services, 2nd Copy: Intake Probation Officer, 3rd Copy: FAST