Attachment 1

Medical Kite

If this is an emergency, tell the Jail staff right away!

☐Dental ☐HIV / AIDS ☐Medical ☐Psychiatric ☐Social Worker ☐Medication Refill

Name: _____ BA # _____
Print Name (#BA)

Alias Name: _____ Birthday: _____
mm/dd/yy

Today's Date: _____ Time: _____ ☐a.m. ☐p.m. Location: _____

Tell us about your health problem: _____

How long have you had this problem? _____

This kite is my permission to get psychiatric or medical or dental exams and treatment from Jail Health Staff.

I understand that the Jail may charge me for some of these services in the amount of $5.00 and deduct it from my account, during this current incarceration or future stays in the jail. I will get health care even if I am unable to pay.

Signature: _____

Do not write below this line!

Date/Time: _____ Refer to Algorithm _____ Allergies _____
BP _____ T _____ R _____ SAO_2 (Oxygen Saturation) _____
P _____ wt. _____ BG _____

Plan/Disposition

☐Priority ☐1 ☐2 ☐3 ☐4
☐Referred to:
☐Reverse Communication
☐Pt. Ed.: _____
☐Treatment Sheet
☐Provider Consulted _____
☐Medication F/ U _____
☐RN Signature & Stamp:

_____

This is a Permanent part of the health record

Public Health
Seattle & King County

Jail Health Services

500 5th Avenue
Seattle, WA 98104
Ph: 206-296-1091
Fax: 206-296-1771

620 W James St
Kent, WA 98032
Ph: 206-205-2410
Fax: 206-205-2439

Form #: PH-1070 (Rev. 1/10)

Medical Kite: Health Record

Patient Name: _____
BA #: _____
HR #: _____
D.O.B.: _____

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