Medical Exam Report

Name:	Inmate Number or Staff Member's Title:
Institution:	Date:

Type of Event: ☐ Accident ☐ Fight ☐ Use of Force ☐ Other _____

Subjective Evaluation: _____

Objective Physical Findings: _____

Nurse's Assessment: _____

Treatment: _____

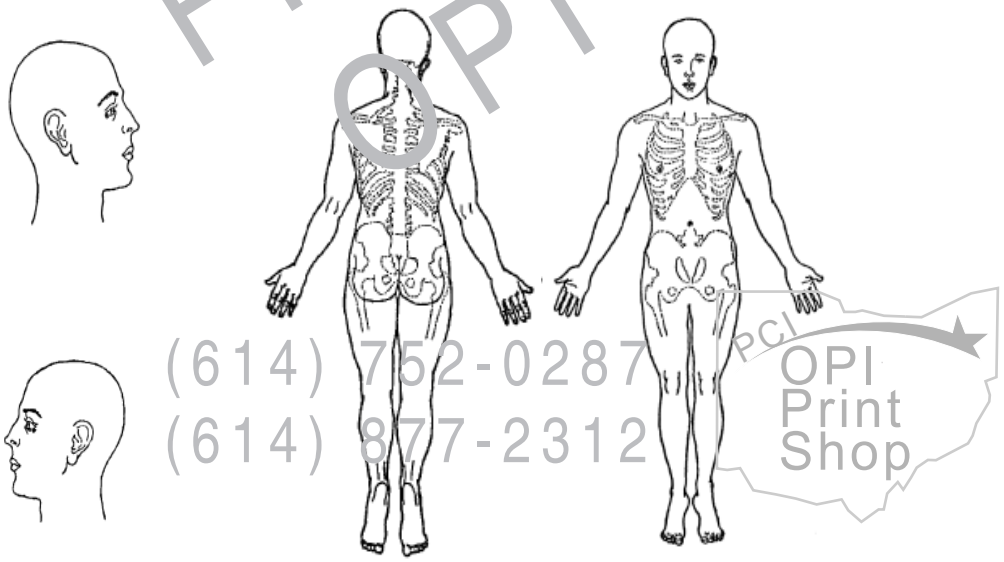
Nurse's Printed Name:	Title:
Nurse's Signature:	Date/Time:

Inmate Disposition:

☐ Released to Housing Unit ☐ Admitted to Infirmary ☐ Transported to Hospital ER
☐ Released to Segregation ☐ Referred to Physician

Staff Disposition:

☐ Returned to Work ☐ Transported to Hospital ER ☐ Referred to Hospital/ER Dept.
☐ Referred to Personal Physician ☐ Other: _____



DISTRIBUTION IF **INMATE**: WHITE - Inmate Medical Record CANARY - Security PINK - (if accident) Health & Safety
DISTRIBUTION IF **EMPLOYEE**: WHITE - Employee CANARY - Security PINK - (if accident) Health & Safety

DRC 5251 (Rev. 02/16)