GENERAL DISTRIBUTION

WEST VIRGINIA
DIVISION OF CORRECTIONS
& REHABILITATION

NUMBER: 413.00

EFFECTIVE DATE: 12 January 2026

SUBJECT: JUVENILE HEALTH SCREENINGS AND APPRAISALS

POLICY DIRECTIVE

PURPOSE:

To provide policy and procedure ensuring an intake health screening commences upon a juvenile's arrival to the facility in order to detect juveniles who pose a health or safety threat to themselves or others and to identify juveniles who require a referral or immediate medical attention; and to ensure a comprehensive health appraisal/assessment and examination are completed within seven days after the juvenile's arrival to the facility.

REFERENCE:

National Commission on Correctional Health Care (NCCHC) §Y-E-02; ACA Expected Practices 5-JCF-5C-01, 03, and 53, 3-JDF-4C-13, 17, 21, and 22, and 2-CO-4E-01; and CIYJ Outcome Measures are Health 01, 02, 05, and 07.

RESPONSIBILITY:

No additional written instructions on this subject are required.

CANCELLATION:

Any previous written instruction on the subject.

APPLICABILITY:

All juvenile facilities within the Division of Corrections and Rehabilitation (DCR). This Policy is available for general distribution.

DEFINITIONS:

Health Care Practitioner/Provider: Clinicians trained to diagnose and treat patients, such as physicians, dentists, psychologists, licensed professional counselors, licensed social workers, podiatrists, optometrists, nurse practitioners, and physician assistants.

Health Care Professional: Staff who perform clinical duties, such as health care practitioners, nurses, licensed professional counselors, social workers, and emergency medical technicians in accordance with each health care professional's scope of training and applicable licensing, registration, certification, and regulatory requirements.

POLICY:

I. Intake health screenings take place in one (1) hour or less from the time of the juvenile resident's arrival at the facility and are performed by qualified health care professional.

A. All findings are recorded on a health-screening form approved by the health authority. The screening includes at least the following:

1. Inquiry into:

a. History of chronic illness and serious infectious or communicable diseases, including symptoms and treatment.

b. Obstetrical/gynecological history and current pregnancy status.

c. Use of alcohol and other drugs, including type(s) of drugs used, mode of use, amounts used, frequency used, date or time of last use, and history of any problems that may have occurred after ceasing use (e.g., convulsions).

d. Current illness and health problems, including infectious or communicable diseases.

e. Current medications.

f. Current dental problems.

g. Mental health problems, including past or present treatment or hospitalization for mental disturbance or suicide attempt.

h. Recording height and weight.

i. Other health problems designated by the responsible physician.

2. Observation of the following:

a. Behavior including state of consciousness, mental status, appearance, conduct, tremor, and sweating.

b. Body deformities and ease of movement.

c. Condition of the skin, including trauma markings, bruises, lesions, jaundice, rashes, and infestations, recent tattoos, and needle marks or other indications of drug abuse.

3. Medical disposition of the resident:

a. Cleared for general population.

b. Cleared for general population with a referral to appropriate health care services.

c. Referral to appropriate health care service for emergency treatment.

B. In facilities without health care staff on site, trained staff members may conduct the health screening as outlined above and established by the DCR Director of Correctional Healthcare. When screening is conducted by trained custody staff, the findings will be recorded on the designated screening form and a subsequent review of positive findings by the licensed health care staff is required.

II. A comprehensive health appraisal/assessment and examination is completed on each resident within seven (7) days of arrival. If there is documented evidence a health examination within the previous ninety (90) days, a new health examination is not required, except as determined by the responsible health care practitioner. The health care practitioner in cooperation with the health authority approves health appraisal and examination data collection and the documentation format.

A. The health appraisal/assessment, completed by a qualified health-care professional, shall include at least the following:

1. Review of the earlier admission screening.

2. Review of the results of the previous medical examinations, tests, and identification of problems.

3. Recording of height, weight, and vital signs (pulse, blood pressure, respiration, and temperature).

4. Collection of additional data to complete the medical, dental, mental health, and immunization histories. (Immunizations are updated, as required, within legal restraints.)

5. Consultation with a health care practitioner, as appropriate.

B. The health examination, completed by a health care practitioner, shall include at least the following:

1. Review of the earlier admission screening results, appraisal data, previous medical examinations, testing, and health problems.

2. Physical examination, including review of mental and dental status.

3. Request for any additional data to complete the medical, dental, mental health, and immunizations histories.

4. Orders for laboratory and/or diagnostic tests to detect communicable disease, including sexually transmitted diseases and tuberculosis.

5. Other tests and examinations, as appropriate.

6. Initiation of therapy, when appropriate.

7. Development and implementation of a treatment plan, including recommendations concerning housing and program participation.

ATTACHMENT(S):

None.

APPROVED SIGNATURE: _____ 12/16/2025

David L. Kelly, Commissioner **Date**