

**DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
STUDENT HEALTH HISTORY**

INSTRUCTIONS: SPONSOR/PARENT/GUARDIAN-READ CAREFULLY AND CHECK (✓) ALL CONDITIONS THAT APPLY TO YOUR CHILD.

Student # _____ Grade _____	STUDENT'S NAME (Print) LAST FIRST MI	CHECK <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/>	Date of Birth: _____/_____/_____ mo day yr
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HEALTH HISTORY

VISUAL DEFECT		COMMENTS	CARDIOVASCULAR		COMMENTS
WEARS GLASSES	<input type="checkbox"/>	<input type="checkbox"/> For Reading ONLY	SICKLE CELL DISORDER	<input type="checkbox"/>	
CONTACTS	<input type="checkbox"/>		ANEMIA	<input type="checkbox"/>	
COLOR DEFICIENCY	<input type="checkbox"/>		CONGENITAL HEART	<input type="checkbox"/>	
OTHER	<input type="checkbox"/>		RHEUMATOID HEART		
HEARING DEFECT	<input checked="" type="checkbox"/>		HEART MURMUR	<input type="checkbox"/>	
EAR INFECTIONS Frequency:	<input type="checkbox"/>	Last Date:	RESTRICTIONS YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	Explain
TUBE IN EAR(S) Left <input type="checkbox"/> Right <input type="checkbox"/>	<input type="checkbox"/>	Date of insertion:	OTHER	<input type="checkbox"/>	
HEARING LOSS	<input checked="" type="checkbox"/>		RESPIRATORY	<input checked="" type="checkbox"/>	
MILD Left <input type="checkbox"/> Right <input type="checkbox"/>	<input type="checkbox"/>	Date Diagnosis:	ASTHMA Date of Diagnosis:	<input type="checkbox"/>	Inhaler needed: @ school YES <input type="checkbox"/> NO <input type="checkbox"/> @ home YES <input type="checkbox"/> NO <input type="checkbox"/>
MODERATE Left <input type="checkbox"/> Right <input type="checkbox"/>	<input type="checkbox"/>	Date Diagnosis:	BRONCHITIS	<input type="checkbox"/>	
SEVERE Left <input type="checkbox"/> Right <input type="checkbox"/>	<input type="checkbox"/>	Date Diagnosis:	CYSTIC FIBROSIS	<input type="checkbox"/>	
HEARING AID(S) Left <input type="checkbox"/> Right <input type="checkbox"/>	<input type="checkbox"/>	Date:	TUBERCULOSIS Date of Diagnosis:	<input type="checkbox"/>	Type of Treatment: Date of Treatment:
CONGENITAL EAR DEFECT Left <input type="checkbox"/> Right <input type="checkbox"/>	<input type="checkbox"/>		NOSEBLEEDS	<input type="checkbox"/>	Frequency:
ALLERGIES	<input checked="" type="checkbox"/>	ANA Kit Required	SINUSITIS	<input type="checkbox"/>	Frequency:
BEE STING	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	DERMATOLOGY	<input checked="" type="checkbox"/>	
FOOD (SPECIFY)	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	PROBLEMS WITH BODY PIERCING/TATOOS	<input type="checkbox"/>	
DRUG (SPECIFY)	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	FEVER BLISTERS COLD SORES	<input type="checkbox"/>	
ENVIRONMENTAL	<input type="checkbox"/>		CONTACT DERMITITIS	<input type="checkbox"/>	
SEASONAL	<input type="checkbox"/>		ACNE	<input type="checkbox"/>	
LACTOSE INTOLERANCE	<input type="checkbox"/>		ECZEMA	<input type="checkbox"/>	
ENDOCRINE	<input checked="" type="checkbox"/>		DANDRUFF	<input type="checkbox"/>	
DIABETES Date Diagnosed:	<input type="checkbox"/>	Insulin needed: @ school YES <input type="checkbox"/> NO <input type="checkbox"/> @ home YES <input type="checkbox"/> NO <input type="checkbox"/>	TINEA (RINGWORM) Body <input type="checkbox"/> Head <input type="checkbox"/> Feet <input type="checkbox"/>	<input type="checkbox"/>	
HYPERGLYCEMIC	<input type="checkbox"/>		MUSCULO/SKELETAL	<input checked="" type="checkbox"/>	
HYPOGLYCEMIC	<input type="checkbox"/>		ARTHRITIS	<input type="checkbox"/>	
THYROID DISORDER	<input type="checkbox"/>		MUSCULAR DYSTROPHY	<input type="checkbox"/>	
PARISITES (HISTORY OF)	<input checked="" type="checkbox"/>		HISTORY OF FRACTURE Explain:	<input type="checkbox"/>	Date:
MALERIA	<input type="checkbox"/>		SCOLIOSIS	<input type="checkbox"/>	Date Diagnosed:
PIN WORMS	<input type="checkbox"/>		DEFORMITY Explain:	<input type="checkbox"/>	
SCABIES	<input type="checkbox"/>		HERNIA	<input type="checkbox"/>	
HEAD LICE	<input type="checkbox"/>		OSGOOD-SCHLATTER	<input type="checkbox"/>	

CONTINUE ON REVERSE SIDE

STUDENT HEALTH HISTORY – CONTINUED

NEUROLOGY		COMMENTS	GASTROINTESTINAL/ GENTOURINARY		COMMENTS
CEREBRAL PALSY	<input type="checkbox"/>		BLADDER CONTROL PROBLEMS Explain:	<input type="checkbox"/>	
SEIZURE DISORDER	<input type="checkbox"/>	Date of last seizure: Medication needed: @ school YES <input type="checkbox"/> NO <input type="checkbox"/> @ home YES <input type="checkbox"/> NO <input type="checkbox"/>	URINARY TRACT INFECTION Explain Frequency:		Date of last infection:
MIGRAINE Specify Frequency	<input type="checkbox"/>	Date of last migraine: Medication needed: @school YES <input type="checkbox"/> NO <input type="checkbox"/> @ home. YES <input type="checkbox"/> NO <input type="checkbox"/>	BOWEL CONTROL PROBLEMS Explain:	<input type="checkbox"/>	
SPINA BIFIDA	<input type="checkbox"/>		DENTAL	<input checked="" type="checkbox"/>	
SLEEP DISORDER	<input type="checkbox"/>		BRACES	<input type="checkbox"/>	
HEADACHES Specify Frequency	<input type="checkbox"/>		CAVITIES: Date of last Dental Exam:		
PSYCHIATRIC	<input checked="" type="checkbox"/>		CANKER SORES		
ATTENTION DEFICT (HYPERACTIVITY) DISORDER ADD/ADHD	<input type="checkbox"/>	Date of Diagnosis: Medication needed: @ school. YES <input type="checkbox"/> NO <input type="checkbox"/> @ home YES <input type="checkbox"/> NO <input type="checkbox"/>	NUTRITION METABOLIC	<input checked="" type="checkbox"/>	
DEPRESSION Date Diagnosed:	<input type="checkbox"/>	Medication needed: @ school YES <input type="checkbox"/> NO <input type="checkbox"/> @ home. YES <input type="checkbox"/> NO <input type="checkbox"/>	NUTRITIONAL PROBLEMS Explain:	<input type="checkbox"/>	
AUTISM	<input type="checkbox"/>		OVERWEIGHT/OBESE	<input type="checkbox"/>	
SUICIDAL History of	<input type="checkbox"/>	Date:	POOR APPEITITE	<input type="checkbox"/>	
SUBSTANCE ABUSE, History of	<input type="checkbox"/>	Circle: Drugs, Alcohol, Tobacco, and/or Inhalants Date:	MISCELLANIOUS	<input checked="" type="checkbox"/>	
ANOREXIA	<input type="checkbox"/>		THUMBSUCKING	<input type="checkbox"/>	
BULIMIA	<input type="checkbox"/>		MOTION SICKNESS	<input type="checkbox"/>	

MEDICATION AND HOSPITALIZATION

<p>DOES YOUR CHILD NEED TO TAKE DAILY MEDICATIONS AT SCHOOL? A medication during school hours form MUST be signed by a physician and a parent and MUST accompany prescribed medications. All medications taken at school MUST be maintained and administered from the health office under school personnel supervision. SPECIFY ALL CURRENT MEDICATIONS (to include medications taken at home):</p>	YES <input type="checkbox"/> NO <input type="checkbox"/>	Comments
<p>HAS YOUR CHILD BEEN HOSPITALIZED? Specify the date and reason: Date: _____ Length of Hospitalization _____ SPECIFY REASON: mo/day/yr.</p>	YES <input type="checkbox"/> NO <input type="checkbox"/>	Comments

SPACE BELOW FOR PARENT TO PROVIDE ADDITIONAL INFORMATION CONCERNING OTHER MEDICAL CONDITIONS.

(PLEASE PRINT)

PRIVACY ACT NOTICE

AUTHORITY: Sections 113, 136 and 2164 of title 10, and 921-932 of title 20 of the United States Code.

PRINCIPAL PURPOSE: To promote student's health for learning.

ROUTINE USE (S): Disclosures are authorized by 5 U.S.C. 552a(b) of the Privacy Act within DoD and outside DoD as a routine use pursuant to DoD Blanket Routine Uses set forth at <http://defenselink.mil/privacy/noticesosd>, authorized by 5 U.S.C. 552a(b)(3).

DISCLOSURE: Voluntary. Without this information school personnel will not be able to provide appropriate education and health services.

Parent/Sponsor's Signature:

Date: