

# 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 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"/>	For Reading ONLY <input type="checkbox"/> Wear Full Time <input type="checkbox"/>	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 <input type="checkbox"/>	
<b>HEARING DEFECT</b> <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"/>	
TUBE IN EAR(S) Left <input type="checkbox"/> Right <input type="checkbox"/>	Date of insertion: _____	Other <input type="checkbox"/>	
<b>HEARING LOSS</b> <input checked="" type="checkbox"/>		<b>RESPIRATORY</b> <input checked="" type="checkbox"/>	
MILD Left <input type="checkbox"/> Right <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"/>		BRONCHITIS <input type="checkbox"/>	
SEVERE Left <input type="checkbox"/> Right <input type="checkbox"/>	Date Diagnosis: 03/23/1995	CYSTIC FIBROSIS <input type="checkbox"/>	
HEARING AID(S) Left <input type="checkbox"/> Right <input type="checkbox"/>	Date: _____	TUBERCULOSIS Date of Diagnosis: _____	Type of Treatment: Date of Treatment: _____
CONGENITAL EAR DEFECT Left <input type="checkbox"/> Right <input type="checkbox"/>		NOSEBLEEDS <input type="checkbox"/>	Frequency: Once a day
<b>ALLERGIES</b> <input checked="" type="checkbox"/>	<b>ANA Kit Required</b>	SINUSITIS <input type="checkbox"/>	Frequency: <b>Once a day</b>
BEE STING <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>DERMATOLOGY</b> <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"/>	
<b>ENDOCRINE</b> <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"/>	
HYPERGLYCEMIC <input type="checkbox"/>		<b>MUSCULO/SKELETAL</b> <input checked="" type="checkbox"/>	
HYPOGLYCEMIC <input type="checkbox"/>		ARTHRITIS <input type="checkbox"/>	
THYROID DISORDER <input type="checkbox"/>		MUSCULAR DYSTROPHY <input type="checkbox"/>	
<b>PARASITES (HISTORY OF)</b> <input checked="" type="checkbox"/>		HISTORY OF FRACTURE Date: _____	Explain: _____
MALERIA <input type="checkbox"/>		SCOLIOSIS <input type="checkbox"/>	Date Diagnosed: _____
PIN WORMS <input type="checkbox"/>		DEFORMITY Explain: _____	
SCABIES <input type="checkbox"/>		HERNIA <input type="checkbox"/>	

HEAD LICE	<input type="checkbox"/>		OSGOOD-SCHLATTER	<input type="checkbox"/>	
NEUROLOGICAL		COMMENTS	GASTROINTESTINAL/ GENITOURINARY		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 - 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 Frequency:	<input type="checkbox"/>		CAVITIES: Date of last Dental Exam:	<input type="checkbox"/>	
PSYCHIATRIC	<input checked="" type="checkbox"/>		CANKER SORES	<input type="checkbox"/>	
ATTENTION DEFICIT (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 APETITTE	<input type="checkbox"/>	
SUBSTANCE ABUSE, History of	<input type="checkbox"/>	Circle: Drugs, Alcohol, Tobacco, and/or Inhalants Date:	MISCELLANEOUS	<input checked="" type="checkbox"/>	
ANOREXIA	<input type="checkbox"/>		THUMBSUCKING	<input type="checkbox"/>	
BULIMIA	<input type="checkbox"/>		MOTION SICKNESS	<input type="checkbox"/>	
<b>MEDICATION AND HOSPITALIZATION</b>					
<b>DOES YOUR CHILD NEED TO TAKE DAILY MEDICATIONS AT SCHOOL?</b> A medication during school hours form <b>MUST</b> be signed by a physician and a parent and <b>MUST</b> accompany prescribed medications. All medications taken at school <b>MUST</b> be maintained and administered from the health office under school personnel supervision. SPECIFY ALL CURRENT MEDICATIONS (to include medications taken at home):				Y E S <input type="radio"/> N O <input checked="" type="radio"/>	Comments:
<b>HAS YOUR CHILD BEEN HOSPITALIZED?</b> Specify the date and reason: Date: _____ Length of Hospitalization _____ SPECIFY REASON:				Y E S <input type="radio"/> N O <input checked="" type="radio"/>	Comments:
SPACE BELOW FOR PARENT TO PROVIDE ADDITIONAL INFORMATION CONCERNING OTHER MEDICAL CONDITIONS. (PLEASE PRINT)					
<b>PRIVACY ACT NOTICE</b> <small>AUTHORITY: Section 113.136 and 2164 of title 10, and 921-932 of title 20 of the United States Code  PRINCIPAL PURPOSE(S): To monitor students' 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 <a href="http://www.defenselink.mil/privacy/notices/osd/">http://www.defenselink.mil/privacy/notices/osd/</a>, authorized by 5 U.S.C. 552a(b) (3).  DISCLOSURE: Voluntary. Without this information school personnel may not be able to provide appropriate education and student health services.</small>					
Parent/Sponsor's Signature:				Date:	