

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 (<u>Print</u>) LAST FIRST MI	CHECK Female <input checked="" type="checkbox"/> Male	Date of Birth: mo day yr
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HEALTH HISTORY

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

HEAD LICE			OSGOOD-SCHLATTER		
NEUROLOGICAL		COMMENTS	GASTROINTESTINAL/ GENITOURINARY		COMMENTS
CEREBRAL PALSY			BLADDER CONTROL PROBLEMS Explain:		
SEIZURE DISORDER		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:		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:		
SPINA BIFIDA			DENTAL	✓	
SLEEP DISORDER			BRACES		
HEADACHES Frequency:			CAVITIES: Date of last Dental Exam:		
PSYCHIATRIC	✓		CANKER SORES		
ATTENTION DEFICIT (HYPERACTIVITY) DISORDER ADD/ADHD		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	✓	
DEPRESSION Date Diagnosed:		Medication needed: @ school YES <input type="checkbox"/> NO <input type="checkbox"/> @ home. YES <input type="checkbox"/> NO <input type="checkbox"/>	NUTRITIONAL PROBLEMS Explain:		
AUTISM			OVERWEIGHT/OBESE		
SUICIDAL History of		Date:	POOR APEITITE		
SUBSTANCE ABUSE, History of		Circle: Drugs, Alcohol, Tobacco, and/or Inhalants Date:	MISCELLANEOUS	✓	
ANOREXIA			THUMBSUCKING		
BULIMIA			MOTION SICKNESS		
MEDICATION AND HOSPITALIZATION					
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 (<i>to include medications taken at home</i>):				Y E S N O	Comments:
HAS YOUR CHILD BEEN HOSPITALIZED? Specify the date and reason: Date: _____ Length of Hospitalization _____ SPECIFY REASON:				Y E S N O	Comments:
SPACE BELOW FOR PARENT TO PROVIDE ADDITIONAL INFORMATION CONCERNING OTHER MEDICAL CONDITIONS. (PLEASE PRINT)					
PRIVACY ACT NOTICE					
<small>AUTHORITY: Section 113.136 and 2164 of title 10, and 921-932 of title 20 of the United States Code PRINCIPAL PUROPSE(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 http://www.defenselink.mil/privacy/notices/osd/, 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: