

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 <input type="checkbox"/>	Date of Birth: mo day yr
--------------------------------	---	--	---------------------------------

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"/>	
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"/>		
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"/>		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:	<input type="checkbox"/>	Type of Treatment: Date of Treatment:
CONGENITAL EAR DEFECT Left <input type="checkbox"/> Right <input type="checkbox"/>			NOSEBLEEDS	<input checked="" type="checkbox"/>	Frequency: Once a day
ALLERGIES	<input checked="" type="checkbox"/>	ANA Kit Required	SINUSITIS	<input type="checkbox"/>	Frequency: Once a day
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"/>		
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 Date:		Explain:
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"/>	
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 (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) Other	<input type="checkbox"/>		CAVITIES: Date of last Dental Exam:	<input type="checkbox"/>	
PSYCHIATRIC	<input checked="" type="checkbox"/>		CANKER SORES	<input type="checkbox"/>	
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					
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):				Y E S <input type="radio"/> N O <input checked="" type="radio"/>	Comments:
HAS YOUR CHILD BEEN HOSPITALIZED? 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)					
PRIVACY ACT NOTICE					
AUTHORITY: Title x, Section 133 7 1076, Title V, Section 301. PRINCIPAL PURPOSE: To record pertinent data concerning student's health. ROUTINE USES: Data is collected and entered into the automated Health Office Management System for use by professional health and education agencies. MANDATORY/VOLUNTARY DISCLOSURE/EFFECT OF NON-DISCLOSURE: Voluntary. Without this information school personnel will not be able to provide appropriate education and health services.					
Parent/Sponsor's Signature:					Date: