

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 M.I.	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"/>	<input type="checkbox"/> For reading ONLY or <input type="checkbox"/> Wears full-time	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 of 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 of diagnosis:	BRONCHITIS	<input type="checkbox"/>	
SEVERE Left <input type="checkbox"/> Right <input type="checkbox"/>	<input type="checkbox"/>	Date of 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 DERMATITIS	<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 of diagnosis:	<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"/>		MUSCULOSKELETAL	<input checked="" type="checkbox"/>	
HYPOGLYCEMIC	<input type="checkbox"/>		ARTHRITIS	<input type="checkbox"/>	
THYROID DISORDER	<input type="checkbox"/>		MUSCULAR DYSTROPHY	<input type="checkbox"/>	
PARASITES (HISTORY OF)	<input checked="" type="checkbox"/>		HISTORY OF FRACTURE Explain:	<input type="checkbox"/>	Date:
MALARIA	<input type="checkbox"/>		SCOLIOSIS	<input type="checkbox"/>	Date of diagnosis:
PINWORMS	<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"/>	

STUDENT HEALTH HISTORY – CONTINUED on the back.

NEUROLOGICAL		COMMENTS	GASTROINTESTINAL/ GENITOURINARY		COMMENTS
CEREBRAL PALSYP	<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 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:		
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 of diagnosis:	<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 APPETITE	<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"/>	

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 supervision of school personnel. SPECIFY ALL CURRENT MEDICATIONS (<i>including medications taken at home</i>):</p>	YES <input type="checkbox"/> NO <input type="checkbox"/>	Comments
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<p>HAS YOUR CHILD BEEN HOSPITALIZED? Specify the date and reason: Date: _____ Length of hospitalization: _____ Reason: mo./day/yr.</p>	YES <input type="checkbox"/> NO <input type="checkbox"/>	Comments
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SPACE BELOW FOR PARENT TO PROVIDE ADDITIONAL INFORMATION CONCERNING OTHER MEDICAL CONDITIONS
(PLEASE PRINT)

_____ My child had the chicken pox vaccine
_____ My child had the chicken pox ____/____ month/year

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

Parent/Sponsor's Signature:	Date:
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