

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 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			HEART MURMUR		
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			RESPIRATORY		
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		ANA Kit Required	SINUSITIS	<input type="checkbox"/>	Frequency:
BEE STING	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	DERMATOLOGY		
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			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			MUSCULOSKELETAL		
HYPOGLYCEMIC	<input type="checkbox"/>		ARTHRITIS	<input type="checkbox"/>	
THYROID DISORDER	<input type="checkbox"/>		MUSCULAR DYSTROPHY	<input type="checkbox"/>	
PARASITES (HISTORY OF)			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		
SLEEP DISORDER	<input type="checkbox"/>		BRACES	<input type="checkbox"/>	
HEADACHES Frequency:	<input type="checkbox"/>		CAVITIES Date of last dental exam:		
PSYCHIATRIC			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		
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		
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 (including medications taken at home):</p>	<p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p>	Comments
<p>HAS YOUR CHILD BEEN HOSPITALIZED? Specify the date and reason: Date: _____ Length of hospitalization: _____ Reason: mo./day/yr.</p>	<p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p>	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 NONDISCLOSURE: Voluntary. Without this information school personnel will not be able to provide appropriate education and health services.

Parent/Sponsor's Signature:

Date: