DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
STUDENT REGISTRATION

INSTRUCTIONS 1. Completed by Sponsor
2. Print (Ink) or type all entries.
3. Leave shaded areas blank.
4. See supplemental sheet for assistance.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 2164, 20 USC 921

PRINCIPAL PURPOSE(S): Required for enrollment of dependents into DoDEA Schools. Provides record of student and sponsor demographic data used in the administration of school programs. Provides emergency contact, pertinent medical and other vital information.

ROUTINE USE(S): Data is collected and entered into the automated School Information Management System for use by DoDEA personnel in providing educational and management programs. Release of student information to non-DoDEA personnel is restricted to U.S. Government personnel and other authorized individuals as approved by DoDEA. Sponsor information may be released to other schools, colleges, and prospective employers as part of the individual student record.

DISCLOSURE: Voluntary. Disclosure of the Social Security Number will expedite the registration process.

SECTION I – STUDENT INFORMATION

1a. Student Number	b. Student Legal Name (Last, First, Middle)		c. Preferred Name
d. Gender ○M ○F	e. Home Phone	f. Student SSN / Unique ID XXXXXXXXXXXXX	g. Student Grade
h. Birth Date (MMMDDYYYY)	i. Field Trip Permission ○Y ○N	j. Sponsor Relationship	k. Employer Type Code
l. Citizenship	m. Home Language Survey Completed ○Y ○N	n. Computer/Internet Permission ○Y ○N	o. Entry / Status Code
p. Student Email Address		q. Previous DoDEA Student ? ○Y ○N	r. Local Use

2a. Student Number	b. Student Legal Name (Last, First, Middle)		c. Preferred Name
d. Gender ○M ○F	e. Home Phone	f. Student SSN / Unique ID XXXXXXXXXXX	g. Student Grade
h. Birth Date (MMMDDYYYY)	i. Field Trip Permission ○Y ○N	j. Sponsor Relationship	k. Employer Type Code
l. Citizenship	m. Home Language Survey Completed ○Y ○N	n. Computer/Internet Permission ○Y ○N	o. Entry / Status Code
p. Student Email Address		q. Previous DoDEA Student ? ○Y ○N	r. Local Use

3a. Student Number	b. Student Legal Name (Last, First, Middle)		c. Preferred Name
d. Gender ○M ○F	e. Home Phone	f. Student SSN / Unique ID XXXXXXXXXXXXX	g. Student Grade
h. Birth Date (MMMDDYYYY)	i. Field Trip Permission ○Y ○N	j. Sponsor Relationship	k. Employer Type Code
l. Citizenship	m. Home Language Survey Completed ○Y ○N	n. Computer/Internet Permission ○Y ○N	o. Entry / Status Code
p. Student Email Address		q. Previous DoDEA Student ? ○Y ○N	r. Local Use

SECTION II – SPONSOR INFORMATION

4. Sponsor's Name (Last, First, Middle Initial)	5. Sponsor SSN/Unique ID XXXXXXXXXXXX	6. Pay/Civ Grade	7. Title / Rank
8. Organization	9. Location of Unit	10. Duty Phone	11. Rotation / ETS Date

12. Spouse's Name (Last, First, Middle Initial)	13. Spouse's Title	14. Spouse's Employer	15. Spouse's Duty Ph.

16. Mailing Address (e.g. APO/FPO) (If different from Physical)	17. Physical Quarters Address (Street, City, State, Zip Code)

18. Sponsor Cell Phone	19. Spouse Cell Phone	20. Email Address
21. Pager Number	22. Reserved	23. Local Use

SECTION III – LOCAL EMERGENCY CONTACT INFORMATION

24a. Emergency Contact Name (Not Sponsor or Spouse)	24b. Contact Duty Phone	24c. Contact Home Phone
24d. Emergency Contact Address (During Day)	24e. Doctor's Name (If not Military Clinic)	24f. Doctor's Phone Number
25a. Emergency Contact 2 Name (Optional)	25b. Contact 2 Duty Phone (Optional)	25c. Contact 2 Home Phone
25d. Emergency Contact 2 Address (Optional)	25e. Local Use	

SECTION IV – PERMANENT STATESIDE / EMERGENCY CONTACT INFORMATION

26a. Contact Name	26b. Contact Home Phone
26c. Contact Address	26d. Relationship to Sponsor

SECTION V – CONSENT and SCHOOL USE INFORMATION

I understand that I have the right to review my child(ren)'s records and that a copy of the school and health records will be released to the next school (exclusive of colleges and universities) he/she/they attend(s) without further approval.

I give permission for my child(ren) to receive first aid at school and any emergency treatment considered necessary with the following exceptions noted below.

I verify the information is correct or has been corrected.

27. Exceptions (If none, enter NONE)			
28. Signature of Sponsor	29. Date (MMMDDYYYY)	40. Registrar's Initials	41. Date (MMMDDYYYY)
30. Reserved	31. Reserved	42. Reserved	
32. Local Use	33. Local Use	43. Local Use	

34. First Day Student Starts School (MMMDDYYYY)	35. DoDAAC HE4427
36. School Name SCHWEINFURT ELEMENTARY SCHOOL	
37. Orders on File / Verified	Y N
38. Birth Date Verified	Y N
39. Reserved	Y N

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY STUDENT REGISTRATION

FORM 700 – Consents and Authorizations

Effective SY ____/____

INSTRUCTIONS **1. Completed by Sponsor** **2. Print (Ink) or type all entries.**

THIS FORM IS APPLICABLE FOR THE DURATION OF YOUR CHILD'S ATTENDANCE AT THE CURRENT SCHOOL YEAR AND WILL REMAIN PERMANENTLY IN THE STUDENT'S FILE. YOU MAY REVIEW AND UPDATE THIS FORM AT ANY TIME.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 2164 and 20 U.S.C. 921-932.
PRINCIPAL PURPOSE: To obtain information necessary to enroll students, administer school operations, and protect student health and welfare in DoD operated dependent educational programs. Completed forms are covered by the DoDEA Dependent Children's School Program Files SORN located at http://privacy.defense.gov/notices/DODEA26.shtml.
ROUTINES USE(STo Federal, State and local government officials to protech health and safety in the event of emergencies. The DoD Blanket Routine Uses found at http://privacy.defense.gov/blanket_uses.shtml also apply to this collection
DISCLOSURE: Voluntary, however, failure to disclose the information collected on this form may delay and/or prevent the enrollment of a child and/or the delivery of educational and emergency services.

1. Last Name	2. First Name	3. Student ID

SPONSOR OR GUARDIAN DESIGNATIONS

1. Field Trips: I permit the student(s) that I am registering with this form to participate in authorized DoDEA school field trips as initiated below: **(Mark the appropriate box)**

☐ **All** scheduled authorized field trips ☐ **Individual** field trip by field trip

2. Media Release: I give permission for my student(s) name and/or image to be used in various media including newsletters, DoDEA web sites (images only), DODEA print and video productions, military community publications, military affiliated publications (Stars & Stripes), military affiliated electronic media (AFN/AFRTS), and public media (local, host nation, U.S. national newspapers, magazines, television). **(Mark the appropriate box)**

☐ Authorize release ☐ Decline release

3. Internet Agreement: I understand that the student(s) I am registering will receive instruction in the appropriate use of DoDEA information technology resources; that in order to use DoDEA resources they must read, understand, and agree to abide by the *Appropriate Use of DoDEA Information Technology Resources – Terms and Conditions for DoDEA Students.* If they violate the Terms and Conditions, I understand they may lose all access privileges on the DoDEA network, and, furthermore, may be subject to school disciplinary and/or appropriate legal actions. **(Mark box indicating agreement)**

☐ Sponsor or Guardian Agreement

4. **11th & 12th grade students only:** I authorize the release of my students' information to military recruiters. **(Mark the appropriate box)**

☐ Authorize release ☐ Decline release

I verify the information is correct or has been corrected.	DATE: (MM/DD/YYYY)
Signature of Sponsor _____	_____

Terms and Conditions

I. Acceptable Use

A. I agree to use DoDEA's computer services only in support of my education and research consistent with the educational objectives of the DoDEA. I will not download files or subscribe to bulletin boards that are not related to my educational activities. If I have questions about my computer use, I will ask my teacher.

B. I will respect and adhere to all of the rules governing access to DoDEA computing resources and the rules of any other network or computing resource to which I have access through the DoDEA equipment.

C. I understand transmission (sent or received) of any material in violation of any U.S. or state regulation is strictly prohibited and may violate criminal law. I will not transmit obscene, sexually suggestive or offensive, lascivious, harassing, or abusive messages, copyrighted material, or material protected by trademark or as a trade secret.

D. I will not publish the name, photograph, home address or telephone number of myself, another student, faculty, or any other person.

E. I understand using the DoDEA computer equipment for commercial, product advertisement or political lobbying is prohibited and may be illegal.

II. Privileges

A. I understand that the use of the network is a privilege, not a right, and use inconsistent with these Terms and Conditions may result in a cancellation of those privileges. (Each student will receive instruction regarding the terms and protocols referenced in this document before network access is provided.)

B. I will be disciplined if I send messages or download files inconsistent with these Terms and Conditions. At the discretion of the principal and teacher, I may lose the privilege of using the Internet permanently and face suspension or expulsion. Copies of the inappropriate materials will be reported to the building administration and kept on file.

III. Internet Etiquette

A. I will be polite. I will not use sexual or abusive language in my messages to others.

B. I will use courteous, respectful language. I will not swear, use vulgarities, sexual, harsh, or disrespectful language. Illegal activities are strictly forbidden.

C. I understand any transmission, including electronic mail, is not private and that my communications and access will be monitored.

D. I will evaluate information carefully. As with any research material, I must review it for accuracy and bias.

E. I will not use the network in such a way as to disrupt the use of the network by other users. This can be avoided by not sending "chain letters," or "broadcast" messages to lists or individuals.

IV. No Warranties

A. I understand DoDEA makes no warranties of any kind, whether expressed or implied, for the service it Is providing. DoDEA is not responsible for any damages I may suffer. This includes loss of data, delays, non-deliveries, misdeliveries, or service interruptions caused by its own negligence or my errors or omissions.

B. I understand the use of any information obtained via DoDEA is at my own risk. DoDEA specifically denies any responsibility for the accuracy or quality of information obtained through its services.

C. I understand DoDEA has no obligation or authority to defend me against any legal actions brought against me by anyone arising from my misuse of DoDEA computer resources or violations of any U.S. or foreign laws.

V. Security

A. I understand security on any computer system is a high priority, especially when the system involves many users. I will notify my teacher if I notice a security problem. I will not demonstrate the problem to other users.

B. I will not give my user password to ot her individuals. Any activity associated with my account will be considered my activity. It is my responsibility to protect my account and password.

C. I may be denied access to the network if I am identified as a security risk.

VI. Vandalism

A. I understand vandalism will result in cancellation of privileges.

B. I will not maliciously attempt to harm or destroy data of another user, Internet, or any other network. This includes, but is not limited to, the uploading or creation of computer viruses.

Department of Defense Education Activity
Questionnaire for Race/Ethnicity and Home Language

Completion of this form is required for enrollment in DoD schools. The data collected is maintained for "Statistical Use Only" and is protected in accordance with the Privacy Act (93-579), OMB Circular A-108, and DoD Directive 5400.11. Unauthorized disclosure of this information constitutes a violation of the Privacy Act and may result in a fine up to $ 5000.

Race/Ethnicity questions comply with OMB Standards for Maintaining, Collecting, and Presenting Data for Race and Ethnicity, dated 30 Oct 97

STUDENT NAME: _____ **DATE:** _____

PLEASE ANSWER ALL SECTIONS

ETHNICITY (Mark one)

_____ **Hispanic or Latino.** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

_____ **NOT Hispanic or Latino.**

RACE (Mark one or more)

_____ **American Indian or Alaska Native.** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

_____ **Asian.** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

_____ **Black or African American.** A person having origins in any of the black racial groups of Africa.

_____ **White.** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

_____ **Native Hawaiian or Other Pacific Islander.** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

HOME LANGUAGE (Yes or No)

1. Does an adult in the household speak a language other than English at home?

_____ Yes _____ No

2. Does the child you are registering speak a language other than English at home?

_____ Yes _____ No

If the answer to either question number 1 or number 2 is "yes," please complete the Home language Questionnaire.

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY

ESL Home Language Questionnaire

Privacy Act Notice: Authority to Collect Information: 20 U.S.C. 927(c) and 10 U.S.C. 2164(f), as amended; E.O 9387; the Privacy Act of 1974, as amended, 5 U.S.C. 552a. **Principal Purpose:** The information will be used within the DoD to determine the services to be provided to a student to assist the child to receive a free appropriate public education. **Disclosure** to the Agency of the information requested on this form is voluntary; but failure to provide all requested information may result in the delay or denial of student services. DoDEA may disclose information requested in this form to other DoD activities and contracted service providers who require the information to deliver educational services to the child and for valid medical, law enforcement or security purposes, or for use in litigation concerning the delivery of student. **Routine Uses:** Disclosure of information contained in this form is authorized outside the DoD in accordance with the "Blanket Routine Uses" described at the beginning of the Office of the Secretary of Defense's compilation of systems of records notices, published at http://www.defenselink.mil/privacy/notice/osd.

THIS FORM IS COMPLETED AT THE TIME OF STUDENT ENROLLMENT

Child's Name: _____ ***Date:*** _____

Grade:_____ **Date of Birth:**_____ **Age:** _____

1. What language is commonly spoken in your home?
   ☐ English ☐ Another Language (Please specify): _____
2. Does the child you are registering speak a language other than English? (Excluding foreign languages studied in school.)
   ☐ No ☐ Yes If yes: What language is spoken? _____
3. What language did your child use when he/she first began to talk?
   ☐ English ☐ Another Language (Please specify) _____
4. Has your child attended English speaking schools?
   ☐ No ☐ Yes If yes: How many years? _____
5. What language does your child read and/or write?
   ☐ English ☐ Another Language (Please specify) _____
6. What language do you most often use when speaking with your child?
   ☐ English ☐ Another Language (Please specify) _____
7. What language does your child use most often when speaking to you?
   ☐ English ☐ Another Language (Please specify) _____
8. If your child is cared for by another person on a regular basis, what language is most often used?
   ☐ English ☐ Another Language (Please specify) _____
9. Do you as a parent need to communicate with the school in a language other than English?
   ☐ No ☐ Yes If yes, in what language? _____

Continued on the next page

ESL Home Language Questionnaire (cont.)

If based on the results of this questionnaire it is necessary to conduct an evaluation, I understand and give my permission for:

1. My child to be evaluated using a standardized language proficiency test and/or academic achievement test to determine whether he/she is eligible for English as a Second Language (ESL) services. Additional information may be collected from my child's teacher(s) and his/her school records.

AND

2. Annual Spring testing to measure my child's academic and English language progress if eligible for services.

I understand that the ESL Teacher will share the results of the assessments with me when testing is completed.

_____ _____

Parent Signature Date

To be completed by ESL Teacher:

Recommendation: ☐ Proficiency Testing ☐ Records Review ☐ No ESL Services Required

Signature of ESL Teacher: _____ Date: _____

Distribution: Original to Student's Cumulative File, Copy to ESL Teacher

SCHWEINFURT ELEMENTARY SCHOOL
"Where Children Matter"

Student Information Form

SY 2010-2011

In order to assist us with in determining the best placement for the child, we would appreciate it if you could provide information on your child's previous education. This information you share will help ensure that your child's educational services are continued. Please understand that the information you provide is voluntary and will only be available for the educators and staff involved in your child's learning progress.

Child's Name: _____ Grade: _____
Full Legal Name

Name of school and date where your child was last enrolled:

_____
School Name City, State MM/DD/YYYY

Type of state or system-wide assessment(s) given (if any):

_____

Was your child enrolled in any special programs? Yes _____ No _____

Please check any programs that apply:

☐	Gifted	☐	READ 180	☐	Foreign Language Immersion
☐	Enrichment	☐	Remedial Reading		
☐	ESL	☐	Math Support	☐	Guidance Program

Other programs: _____

_____

Should we expect to receive a supplemental file form your child's previous school?

Yes _____ No _____

Thank you for allowing us to be a part of your child's education!

REQUEST FOR STUDENT RECORDS	DATE:	

PRIVACY ACT NOTICE

AUTHORITY: Title V, USC, Section 22a
ROUTINE USES: Used by School and Records managers in all elements of DoDDS-A to request records for students enrolling. Personal data cited is derived from enrollment form and is required for records locator purposes. Release signature required under the 1974 Privacy Act to authorize transmittal of student records. A record copy of this request maintained by requestors for a five-year period for any records released to non-DoD activities.
MANDATORY/VOLUNTARY DISCLOSURE/EFFECT OF NON-DISCLOSURE: An authorizing signature is mandatory under the Privacy Act to release records. Failure to sign will result in records not being released.

TO: *Previous School*		From: *New School*	SCHWEINFURT ELEMENTARY SCHOOL- ATTN: REGISTRAR UNIT: 25850 PO BOX 1 APO, AE 09033

NAME OF STUDENT(S)			DATE OF BIRTH	ATTENDED YOUR SCHOOL	
Last Name	First Name	MI	Mo/Day/Yr	Withdrawal Date	Last Grade

The student(s) identified above has /have enrolled in our school. This/these student(s)'s **report card(s)**, **cumulative folder(s)**, **health record(s)**, and any **special education record(s)** are requested.

In accordance with the provisions of the Family Educational Rights and Privacy Act of 1974 (and for DoDDS-A schools, the DoDDS-A Policy statement for the Collections, Maintenance, and dissemination of Pupil Records, dated 16 September 1974), listed below is the written authorization for release of records and files for the above named student(s) to the school shown above.

I, (Sponsor)_____, do hereby request and authorize the release of records and files for the above named student(s) to the school shown above.

Signature of Sponsor (Authorizing Agent)		Date Signed
Venice L. Anderson-Registrar		
Type/Print Name of Requestor (School Personnel)	Signature	

DSA 105 (Nov 89) Previous editions are obsolete and will not be used.

Schweinfurt Elementary School
Alternate Destination Information

Please indicate by checking ONE selection below what your child's transportation method is to return home each day.

□ Walker □ Bus Rider #_____ □ SAS Other_____

Student(s) Name	*Grade*	*Teacher*
1.		
2.		
3.		
4.		

Contact Information		
Sponsor's Name		Sponsor's Unit
Home Phone #		Sponsor's Company
Cell Phone #		1st Sergeant Name
Duty Phone #		1st Sergeant Phone #
Spouse's Name		
Home Phone #		
Cell Phone #		
Duty or Work Phone #		
Emergency Contact #1 Name		
Home Phone #		
Cell Phone #		
Duty or Work Phone #		
Emergency Contact #2 Name		
Home Phone #		
Cell Phone #		
Duty or Work Phone #		

If Force Protection levels elevates or weather conditions deteriorates while students are at school we need instructions from you regarding how you wish to transport your child. Please indicate by initialing one selection below.

_____ I DO NOT authorize any emergency contact pickup of my child(ren).

_____ I DO authorize emergency contact to pickup my child(ren).

_____ Allow my child(ren) to walk home as usual.

_____ Allow my child(ren) to take the bus home.

_____ Keep my child(ren) at school until the sponsor, spouse or emergency contact picks them up.

By signing below I am confirming that I have discussed with my child(ren) who their emergency contacts are and what to do in the event school is dismissed early or in case of an emergency.

PRINTED NAME _____ SIGNATURE _____ DATE _____

Alternate Destination Information Updates

Item to Update	Change To	Date Requested	Completed By	Date Completed

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 ☐ Male ☐	Date of Birth: mo day yr

HEALTH HISTORY

VISUAL DEFECT		COMMENTS	CARDIOVASCULAR		COMMENTS
WEARS GLASSES	☐	For Reading ONLY ☐ Wear Full Time ☐	SICKLE CELL DISORDER	☐	
CONTACTS	☐		ANEMIA	☐	
COLOR DEFIENCY	☐		CONGENITAL HEART	☐	
OTHER	☐		RHEUMATOID HEART	☐	
HEARING DEFECT	✓		HEART MURMUR	☐	
EAR INFECTIONS Frequency:	☐	Last Date: Last Date:	RESTRICTIONS YES ☐ NO ☐		
TUBE IN EAR(S) Left ☐ Right ☐	☐	Date of insertion:	Other	☐	
HEARING LOSS	✓		**RESPIRATORY**	✓	
MILD Left ☐ Right ☐		Date Diagnosis:	ASTHMA Date of Diagnosis:	☐	**Inhaler needed:** @ school YES ☐ NO ☐ @ home YES ☐ NO ☐
MODERATE Left ☐ Right ☐			BRONCHITIS	☐	
SEVERE Left ☐ Right ☐		Date Diagnosis:	CYSTIC FIBROSIS	☐	
HEARING AID(S) Left ☐ Right ☐		Date:	TUBERCULOSIS Date of Diagnosis:	☐	Type of Treatment: Date of Treatment:
CONGENITAL EAR DEFECT Left ☐ Right ☐			NOSEBLEEDS	☐	Frequency: Once a day
ALLERGIES	✓	**ANA Kit Required**	SINUSITIS	☐	Frequency: Once a day
BEE STING	☐	YES ☐ NO ☐	**DERMATOLOGY**	✓	
FOOD (SPECIFY)	☐	YES ☐ NO ☐	PROBLEMS WITH BODY PIERCING/TATOOS	☐	
DRUG (SPECIFY)	☐	YES ☐ NO ☐	FEVER BLISTERS COLD SORES	☐	
ENVIRONMENTAL	☐		CONTACT DERMITITIS	☐	
SEASONAL	☐		ACNE	☐	
LACTOSE INTOLERANCE	☐		ECZEMA	☐	
ENDOCRINE	✓		DANDRUFF	☐	
DIABETES Date Diagnosed:	☐	**Insulin needed:** @ school YES ☐ NO ☐ @ home YES ☐ NO ☐	TINEA (RINGWORM) Body ☐ Head ☐ Feet ☐		
HYPERGLYCEMIC	☐		**MUSCULO/SKELETAL**	✓	
HYPOGLYCEMIC	☐		ARTHRITIS	☐	
THYROID DISORDER	☐		MUSCULAR DYSTROPHY	☐	
PARISITES (HISTORY OF)	✓		HISTORY OF FRACTURE Date:		Explain:
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 ☐ NO ☐ **@ home** YES ☐ NO ☐	URINARY TRACT INFECTION Explain Frequency:		Date of last infection:
MIGRAINE - Frequency:	☐	Date of last migraine: **Medication needed:** **@school** YES ☐ NO ☐ **@ home.** YES ☐ NO ☐	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 ☐ NO ☐ **@ home** YES ☐ NO ☐	**NUTRITION METABOLIC**	✓	
DEPRESSION Date Diagnosed:	☐	**Medication needed:** **@ school** YES ☐ NO ☐ **@ home.** YES ☐ NO ☐	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 (*to include medications taken at home):*	YES ○ NO ○	Comments:
HAS YOUR CHILD BEEN HOSPITALIZED? Specify the date and reason: Date: _____ Length of Hospitalization_____ SPECIFY REASON:	YES ○ NO ○	Comments:

SPACE BELOW FOR PARENT TO PROVIDE ADDITIONAL INFORMATION CONCERNING OTHER MEDICAL CONDITIONS.
(PLEASE PRINT)

PRIVACY ACT NOTICE

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 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.

Parent/Sponsor's Signature:	Date:

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
IMMUNIZATION REQUIREMENTS

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 113, 126, 2164 and 20 U.S.C. 921-932; E.O 9387; the Privacy Act of 1974, as amended, 5 U.S.C. 552a.

PRINCIPAL PURPOSE: The information may be used within the Department of Defense (DoD) to determine what immunizations have been administered for purposes of determining enrollment eligibility and for use in preserving school health.

ROUTINES USE(S): The Department of Defense Education Activity (DoDEA) may release information without prior consent with the DoD when needed to perform an official DoD duty, in accordance with 5 U.S.C. 552a(b). In addition, in accordance with 5 U.S.C. 552a(b)(3), information contained therein may be disclosed outside the DoD as a routine use pursuant to "Blanket Routine Uses," as published at http://www.defenselink.mil/privacy/notice/osd, for example, for valid medical, law enforcement or security purposes, or for use in litigation involving the DoD.

DISCLOSURE: Disclosure to the Agency of the information requested on this form is voluntary; but failure to provide all requested information may result in the delay or denial of student services.

Students who enroll in DoDEA schools MUST meet specific immunization requirements. These requirements, displayed below, represent the minimum requirement and do not necessarily reflect the optimal immunization status for a student. This copy of the DoDEA Immunization Requirements is provided to parents for informational purposes. This form does not need to be completed by medical authority. However, some type of medical proof of immunization must be completed by medical authority and provided to school officials at the time of initial registration. This form may be used by medical officials if so desired. If this form is used by medical officials, page 4 must be completed.

STUDENT: _____ **Date of Birth (MM/DD/YY):** _____

IMMUNIZATION	Dose Number	Name of Vaccine	Date Immunized	MINIMUM DoD REQUIREMENTS *
Diphtheria, Tetanus, Pertussis e.g., DTP, DtaP, DTwP, DT, DtaP-Hib, DtaP-HepB-IPV, Tdap,Td	#1			**Four (4) doses.** At least one dose must be administered **after** the 4th birthday. ***ACIP Recommendation:** • The usual schedule is a primary series of 4 doses at 2m, 4m, 6m, and 15-18m of age. • If the fourth dose of DT, DTP or DTaP is administered before the fourth birthday, a booster (fifth) dose is recommended at 4–6 years of age (5[a]). **Td or Tdap booster doses:** A single Tdap booster dose is recommended for children 11-12 years old, if 5 years elapsed since the last dose; then boost every 10 years with Td (5[b]).
	#2			
	#3			
	#4			
	#5[a]			
	#5[b]			
Hepatitis A e.g., HepA	#1			**Two (2) doses.** **ACIP Recommendation:** • HepA is recommended for all children at 1 year of age. • The two doses in the series should be administered at least 6 months apart.
	#2			

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
IMMUNIZATION REQUIREMENTS

IMMUNIZATION	Dose Number	Name of Vaccine	Date Immunized	MINIMUM DoD REQUIREMENTS *
Hepatitis B e.g., HepB, Hib-HepB, DTaP-HepB-IPV	#1			**Three (3) doses.** **ACIP Recommendation:** • The standard schedule is 0, 1 and 6 months. • The first dose is recommended shortly after birth, with the second dose administered at age 1 to 2 months. The third dose should be administered at age ≥ 24 weeks. • Merck's Recombivax-HB brand of HepB vaccine can be given as a 2-dose series for adolescents 11 to 15 years of age. **Catch-up schedule:** • 3-dose series may be started at any age. • Minimum spacing for children and teens: 4 weeks between dose 1 and dose 2, and 8 weeks between dose 2 and dose 3.
	#2			
	#3			
Haemophilus influenzae type b e.g., Hib, Hib-HepB, DtaP-Hib	#1			**Two (2) to four (4) doses.** **ACIP Recommendation:** • Primary immunization occurs at 2m, 4m, 6m, and 12m to 15m (booster dose). • For Merck's PedvaxHIB brand of Hib vaccine, 3 doses are needed (2, 4, and 12-15m). **Catch-up schedule:** • If dose 1 is given at 12-14m, give a booster dose 8 weeks later. • Unvaccinated children from the ages of 15m up to 5 years need only 1 dose. Hib is not routinely given to children **5 years old and older.**
	#2			
	#3			
	#4			
Polio e.g., IPV, DTap-HepB-IPV **Note:** Oral Polio Vaccine (OPV) counts for immunization requirements, but is no longer distributed in the U.S.	#1			**Three (3) doses.** At least one dose must be administered **after** the 4th birthday. **ACIP Recommendation:** • Usual schedule is a primary series of 4 doses at 2m, 4m, 6-18m, and 4-6 years of age. • All doses should be separated by at least 4 weeks. • If dose 3 is given after the 4th birthday, dose 4 is not needed.
	#2			
	#3			
	#4			
Meningococcal				**ACIP Recommendation:** • Meningococcal vaccine (MCV4). Meningococcal conjugate vaccine (MCV4) should be given to all children at the 11–12 year old visit as well as to unvaccinated adolescents at high school entry (15 years of age). Other adolescents who wish to decrease their risk for meningococcal disease may also be vaccinated. • All college freshmen living in dormitories should also be vaccinated, preferably with MCV4, although meningococcal **polysaccharide vaccine (MPSV4)** is an acceptable alternative. • Vaccination against invasive meningococcal disease is recommended for children and adolescents aged ≥ 2 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high risk groups (see *MMWR* 2005;54 [RR-7]:1-21); use MPSV4 for children aged 2–10 years and MCV4 for older children, although MPSV4 is an acceptable alternative.

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
IMMUNIZATION REQUIREMENTS

IMMUNIZATION	Dose Number	Name of Vaccine	Date Immunized	MINIMUM DoD REQUIREMENTS *
Measles, Mumps, Rubella e.g., MMR, MMRV	#1			**Two (2) doses.** **ACIP Recommendation:** • Dose 1 is given at 12-15m of age. • Dose 2 is recommended routinely at age 4-6 years, but may be administered at any visit if 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months. • Those who have not previously received the second dose should complete the schedule by age 11-12 years.
	#2			
PPD **TB tine/monovac**	**Date of last test:**	**No Vaccination Required**	**Result:** ☐ Positive ☐ Negative _____ **mm induration**	**Tuberculosis (TB) testing recommended.** Frequency determined by local medical command. If **positive**, date of chest X-ray: _____/_____/_____ Chest X-ray Results: _____ Date isoniazid (INH) treatment started: _____/_____/_____ Date INH treatment completed: _____/_____/_____
Varicella e.g. Var, MMRV	#1			**ACIP Recommendation:** • Immunize all children age 1 year and older, including adolescents who have not had chickenpox. • Susceptible children age 1 year and older receive 1 dose. • **Susceptible people age 13 and older** should receive **two (2) doses** at least 4 to 8 weeks apart. ► **Immunization is NOT required in people with a history of natural disease (chickenpox).**
	#2			
	History of naturally acquired chickenpox		**Date:**	

Notes

* Advisory Committee on Immunization Practices (ACIP).
[a] The fifth dose is not required if the fourth dose was given on or after the fourth birthday.
[b] Second dose required only in susceptible people 13 years old or older.
* The standard and catch-up pediatric and adolescent immunization schedules adopted by the CDC are posted at www.dcd.gov/nip/recs/child-schedule-color-print.pdf and www.cdc.gov/nip/recs/adult-schedule.pdf .

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
CERTIFICATE OF IMMUNIZATION

STUDENT: _____ **Date of Birth (MM/DD/YY):** _____

Immunization records for the student named above have been reviewed at _____
Location of Clinic

I certify that the minimum immunization requirements have been completed and/or initiated.

Immunizations are current until _____ **when immunization(s) is/are due.**

_____ _____
Signature and Stamp of Medical Authority **Date**

A request for an immunization waiver for **medical** reasons must be supported by official documents from a medical authority and provided to the school at the time of registration.
I certify that the minimum immunization requirements have been waived.

Immunization(s): _____ **Reason:** _____

Waiver Duration: _____ _____
Signature and Stamp of Medical Authority **Date**