DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
STUDENT HEALTH HISTORY

2009-2010

INSTRUCTIONS: SPONSOR/PARENT/GUARDIAN-READ CAREFULLY AND CHECK (ü) ALL CONDITIONS THAT APPLY TO YOUR CHILD.

Student #_____ Grade_____	**STUDENT'S NAME (Print) LAST FIRST M.I.**	CHECK ü Female ☐ Male ☐	Date of Birth: _____/_____/_____ mo. day yr.

HEALTH HISTORY

VISUAL DEFECT		COMMENTS	CARDIOVASCULAR		COMMENTS
WEARS GLASSES	☐	ÿ For reading **ONLY** or ÿ Wears full-time	SICKLE CELL DISORDER	☐	
CONTACTS	☐		ANEMIA	☐	
COLOR DEFICIENCY	☐		CONGENITAL HEART	☐	
OTHER	☐		RHEUMATOID HEART		
HEARING DEFECT	ü		HEART MURMUR	☐	
EAR INFECTIONS Frequency:	☐	Last date:	RESTRICTIONS YES ÿ NO ÿ	☐	Explain:
TUBE IN EAR(S) Left ÿ Right ÿ	☐	Date of insertion:	OTHER	☐	
HEARING LOSS	ü		**RESPIRATORY**	ü	
MILD Left ÿ Right ÿ	☐	Date of diagnosis:	ASTHMA Date of diagnosis:	☐	**Inhaler needed:** **@ school** YES ÿ NO ÿ **@ home** YES ÿ NO ÿ
MODERATE Left ÿ Right ÿ	☐	Date of diagnosis:	BRONCHITIS	☐	
SEVERE Left ÿ Right ÿ	☐	Date of diagnosis:	CYSTIC FIBROSIS	☐	
HEARING AID(S) Left ÿ Right ÿ	☐	Date:	TUBERCULOSIS Date of diagnosis:	☐	Type of treatment: Date of treatment:
CONGENITAL EAR DEFECT Left ÿ Right ÿ	☐		NOSEBLEEDS	☐	Frequency:
ALLERGIES	ü	**ANA Kit Required**	SINUSITIS	☐	Frequency:
BEE STING	☐	YES ÿ NO ÿ	**DERMATOLOGY**	ü	
FOOD Specify:	☐	YES ÿ NO ÿ	PROBLEMS WITH BODY PIERCING/TATOOS	☐	
DRUG Specify:	☐	YES ÿ NO ÿ	FEVER BLISTERS COLD SORES	☐	
ENVIRONMENTAL	☐		CONTACT DERMATITIS	☐	
SEASONAL	☐		ACNE	☐	
LACTOSE INTOLERANCE	☐		ECZEMA	☐	
ENDOCRINE	ü		DANDRUFF	☐	
DIABETES Date of diagnosis:	☐	**Insulin needed:** **@ school** YES ÿ NOÿ **@ home** YES ÿ NO ÿ	TINEA (RINGWORM) Body ÿ Head ÿ Feet ÿ	☐	
HYPERGLYCEMIC	☐		**MUSCULOSKELETAL**	ü	
HYPOGLYCEMIC	☐		ARTHRITIS	☐	
THYROID DISORDER	☐		MUSCULAR DYSTROPHY	☐	
PARASITES (HISTORY OF)	ü		HISTORY OF FRACTURE Explain:	☐	Date:
MALARIA	☐		SCOLIOSIS	☐	Date of diagnosis:
PINWORMS	☐		DEFORMITY Explain:	☐	
SCABIES	☐		HERNIA	☐	
HEAD LICE	☐		OSGOOD-SCHLATTER	☐	

STUDENT HEALTH HISTORY – CONTINUED on the back.

NEUROLOGICAL		COMMENTS	GASTROINTESTINAL/ GENITOURINARY		COMMENTS
CEREBRAL PALSY	☐		BLADDER CONTROL PROBLEMS Explain:	☐	
SEIZURE DISORDER	☐	Date of last seizure: **Medication needed:** **@ school** YES ÿ NO ÿ **@ home** YES ÿ NO ÿ	URINARY TRACT INFECTION Frequency:		Date of last infection:
MIGRAINE Frequency:	☐	Date of last migraine: **Medication needed:** **@ school** YES ÿ NO ÿ **@ home** YES ÿ NO ÿ	BOWEL CONTROL PROBLEMS Explain:	☐	
SPINA BIFIDA	☐		**DENTAL**	ü	
SLEEP DISORDER	☐		BRACES	☐	
HEADACHES Frequency:	☐		CAVITIES Date of last dental exam:		
PSYCHIATRIC	ü		CANKER SORES		
ATTENTION DEFICT (HYPERACTIVITY) DISORDER ADD/ADHD	☐	**Date of diagnosis:** **Medication needed:** **@ school** YES ÿ NO ÿ **@ home** YES ÿ NO ÿ	**NUTRITION METABOLIC**	ü	
DEPRESSION Date of diagnosis:	☐	**Medication needed:** **@ school** YES ÿ NO ÿ **@ home** YES ÿ NO ÿ	NUTRITIONAL PROBLEMS Explain:	☐	
AUTISM	☐		OVERWEIGHT/OBESE	☐	
SUICIDAL, History of	☐	Date:	POOR APPETITE	☐	
SUBSTANCE ABUSE, History of	☐	Circle: Drugs, alcohol, tobacco, and/or inhalants Date:	**MISCELLANEOUS**	ü	
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 supervision of school personnel. SPECIFY ALL CURRENT MEDICATIONS *(including medications taken at home):*	YES ☐ NO ☐	Comments
HAS YOUR CHILD BEEN HOSPITALIZED? Specify the date and reason: Date: _____ Length of hospitalization**:** _____ Reason: mo./day/yr.	YES ☐ NO ☐	Comments

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:**