DEPARTMENT OF DEFENSE EDUCATION ACTIVITY

STUDENT HEALTH HISTORY

INSTRUCTIONS: 1. SPONSOR/PARENT IS TO COMPLETE ONE (1) COLUMN YEARLY 2. CHECK ALL CONDITIONS THAT APPLY for CURRENT SY

Student #_____ Grade_____	**STUDENT'S NAME (Print) LAST FIRST MI** HP: DP: CP: email:	CHECK ✓ Female ☐ Male ☐	Date of Birth: _____/_____/_____ mo day yr

HEALTH HISTORY

VISUAL DEFECT	**Yr.1**	**2**	**3 COMMENTS**	**CARDIOVASCULAR**	**Yr. 1**	**2**	**3 COMMENTS**
WEARS GLASSES	☐	☐	☐ For Reading **ONLY** ☐	SICKLE CELL DISORDER	☐	☐	☐
CONTACTS	☐	☐	☐	ANEMIA	☐	☐	☐
COLOR BLIND	☐	☐	☐	CONGENITAL HEART	☐	☐	☐
OTHER	☐	☐	☐	RHEUMATOID HEART			
HEARING DEFECT				HEART MURMUR	☐	☐	☐
EAR INFECTIONS Frequency:	☐	☐	☐ Last Date:	RESTRICTIONS YES ☐ NO ☐	☐	☐	☐ (Explain)
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 ☐
MODERATE Left ☐ Right ☐	☐	☐	☐ Date Diagnosis:	BRONCHITIS	☐	☐	☐
SEVERE Left ☐ Right ☐	☐	☐	☐ Date Diagnosis:	CYSTIC FIBROSIS	☐	☐	☐
HEARING AID(S) Left ☐ Right ☐	☐	☐	☐ Date:	+ IPPD or TUBERCULOSIS date: CXR normal or _____ date:	☐	☐	☐ Treated with INH x _____ completed date: _____
CONGENITAL EAR DEFECT Left ☐ Right ☐	☐	☐	☐	NOSEBLEEDS	☐	☐	☐ Frequency:
ALLERGIES			**EPI PEN / ANA Kit**	SINUSITIS	☐	☐	☐ Frequency:
BEE STING	☐	☐	☐ YES ☐ NO ☐	**DERMATOLOGY**			
FOOD (SPECIFY)	☐	☐	☐ YES ☐ NO ☐	PROBLEMS WITH BODY PIERCING/TATOOS	☐	☐	☐
DRUG (SPECIFY)	☐	☐	☐ YES ☐ NO ☐	FEVER BLISTERS COLD SORES	☐	☐	☐
ENVIRONMENTAL	☐	☐	☐	CONTACT DERMATITIS	☐	☐	☐
SEASONAL	☐	☐	☐	ACNE	☐	☐	☐
LACTOSE INTOLERANCE	☐	☐	☐	ECZEMA	☐	☐	☐
ENDOCRINE				DANDRUFF	☐	☐	☐
DIABETES Date of Diagnosis:	☐	☐	☐ **Insulin needed @Home/@School** YES ☐ NO ☐	TINEA (RINGWORM) Body ☐ Head ☐ Feet ☐	☐	☐	☐
HYPERGLYCEMIC	☐	☐	☐	**MUSCULO/SKELETAL**			
HYPOGLYCEMIC	☐	☐	☐	ARTHRITIS	☐	☐	☐
THYROID DISORDER	☐	☐	☐	MUSCULAR DYSTROPHY	☐	☐	☐
PARASITES (HISTORY OF)				HISTORY OF FRACTURE Explain:	☐	☐	☐
MALARIA	☐	☐	☐	SCOLIOSIS	☐	☐	☐
PIN WORMS	☐	☐	☐	DEFORMITY Explain:	☐	☐	☐
SCABIES	☐	☐	☐	HERNIA	☐	☐	☐
HEAD LICE	☐	☐	☐	OSGOOD-SCHLATTER	☐	☐	☐

CONTINUE ON REVERSE SIDE

STUDENT HEALTH HISTORY -- CONTINUED

NEUROLOGY	Yr.1	2	3 COMMENTS	GASTROINTESTINAL/ GENITOURINARY	Yr.1	2	3 COMMENTS
CEREBRAL PALSY	☐	☐	☐	BLADDER CONTROL PROBLEMS Explain:	☐	☐	☐
SEIZURE DISORDER Date of last seizure:	☐	☐	Medication needed @Home/@School YES ☐ NO ☐ Name of Rx:	URINARY TRACT INFECTION Explain Frequency:		☐	☐ Date of last infection:
MIGRAINE Specify Frequency Date of last seizure:	☐	☐	Medication needed @Home/@School YES ☐ NO ☐ Name of Rx:	BOWEL CONTROL PROBLEMS Explain:	☐	☐	☐
SPINA BIFIDA	☐	☐	☐	**DENTAL**			
SLEEP DISORDER	☐	☐	☐	BRACES	☐	☐	☐
HEADACHES Specify Frequency	☐	☐	☐	CAVITIES: Date of last Dental Exam:			
MEDICAL/ BEHAVIORAL				CANKER SORES			
ATTENTION DEFICIT (HYPERACTIVITY) DISORDER ADD/ADHD	☐	☐	☐ Date of Diagnosis: Medication needed @Home/@School YES ☐ NO ☐ Name of Rx:	**NUTRITION METABOLIC**			
DEPRESSION Date Diagnosed:	☐	☐	☐ Medication needed @Home/ @School YES ☐ NO ☐ Name of Rx:	NUTRITIONAL PROBLEMS Explain:	☐	☐	☐
AUTISM	☐	☐	☐	OVERWEIGHT/OBESE	☐	☐	☐
SUICIDAL History of	☐	☐	☐ Date:	POOR APPEITITE	☐	☐	☐
SUBSTANCE ABUSE History of	☐	☐	☐ Circle: Drugs, Alcohol, Tobacco, and/or Inhalants Date:	**MISCELLANIOUS** Had the chicken pox			If yes, when _____
ANOREXIA	☐	☐	☐	THUMBSUCKING	☐	☐	☐
BULIMIA	☐	☐	☐	MOTION SICKNESS	☐	☐	☐

MEDICATION AND HOSPITALIZATION

	Yr. 1	2	3	Comments
DOES YOUR CHILD NEED TO TAKE DAILY MEDICATIONS AT SCHOOL? Hold Harmless (DSPA Form 126) permission for medication 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 ☐	YES☐ NO ☐	YES☐ NO ☐	
HAS YOUR CHILD BEEN HOSPITALIZED? Specify the date and reason: Date: _____ Length of Hospitalization_____ SPECIFY REASON:	YES☐ NO ☐	YES☐ NO ☐	YES☐ NO ☐	Comments

SPACE BELOW FOR PARENT TO PROVIDE ADDITIONAL INFORMATION CONCERNING OTHER MEDICAL CONDITIONS.

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.

Year 1 Parent/Sponsor's Signature:	**Date:**
Year 2 Parent/Sponsor's Signature:	**Date:**
Year 3 Parent/Sponsor's Signature:	**Date:**