Print Form

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**	SICKLE CELL DISORDER	☐	
CONTACTS	☐		ANEMIA	☐	
COLOR DEFIENCY	☐		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 ☐ **@ home** YES ☐ NO ☐
MODERATE Left ☐ Right ☐	☐	Date Diagnosis:	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:
ALLERGIES	✓	**ANA Kit Required**	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 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 Explain:	☐	Date:
MALERIA	☐		SCOLIOSIS	☐	Date Diagnosed:
PIN WORMS	☐		DEFORMITY Explain:	☐	
SCABIES	☐		HERNIA	☐	
HEAD LICE	☐		OSGOOD-SCHLATTER	☐	

CONTINUE ON REVERSE SIDE

STUDENT HEALTH HISTORY – CONTINUED

NEUROLOGY	✓	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 Specify Frequency	☐	Date of last migraine: **Medication needed:** **@school** YES ☐ NO ☐ **@ home.** YES ☐ NO ☐	BOWEL CONTROL PROBLEMS Explain:	☐	
SPINA BIFIDA	☐		**DENTAL**	✓	
SLEEP DISORDER	☐		BRACES	☐	
HEADACHES Specify Frequency	☐		CAVITIES: Date of last Dental Exam:		
PSYCHIATRIC	✓		CANKER SORES	☐	
ATTENTION DEFICT (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 APPEITITE	☐	
SUBSTANCE ABUSE, History of	☐	Circle: Drugs, Alcohol, Tobacco, and/or Inhalants Date:	**MISCELLANIOUS**	✓	
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: mo/day/yr.	YES ☐ NO ☐	Comments

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

(PLEASE PRINT)

PRIVACY ACT NOTICE

AUTHORITY: Sections 113, 136 and 2164 of title 10, and 921-932 of title 20 of the United States Code.
PRINCIPAL PURPOSE: To promote student's 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 fort at http://defenselink.mil/privacy/noticesosd, authorized by 5 U.S.C. 552a(b)(3).
DISCLOSURE: Voluntary. Without this information school personnel will not be able to provide appropriate education and health services.

Parent/Sponsor's Signature:	**Date:**