INFANT, CHILD AND ADOLESCENT HEALTH ASSESSMENT

DATA REQUIRED BY THE PRIVACY ACT OF 1994

PRINCIPAL PURPOSE: Information is used by DA personnel to: (1) verify child health status of immunization per admission requirements; (2) note special program considerations or restriction on child participation; (3) execute emergency medical procedures for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program. **ROUTINE USES:** No information is disclosed outside DOD. **DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in community activities.

NAME OF SPONSOR	DEROS	TELEPHONE (HOME)	TELEPHONE (DUTY)

SPONSOR UNIT ADDRESS	SPONSOR SSN	SPOUSE'S WORK PHONE

CHILD HEALTH INFORMATION (SPONSOR)

NAME OF CHILD	BIRTH DATE	SEX

HAS YOUR CHILD BEEN UNDER THE SUPERVISION OF A PHYSICIAN? (IF YES EXPLAIN CIRCUMSTANCES AND CURRENT STATUS)

IS CHILD ENROLLED IN EXCEPTIONAL FAMILY MEMBER PROGRAM NO / YES LAST UPDATE:

PLEASE ATTACH COPY OF IMMUNIZATIONS

MEDICAL HISTORY

	YES	NO		YES	NO
1. ANY HOSPITALIZATION OR OPERATIONS			14. HEAT STROKE OR EXHAUSTION		
2. ALLERGIES TO MEDICINE OR INSECT BITES			15. BROKEN BONES OR SPRAINS		
3. SPEECH OR DEVELOPMENTAL DELAYS			16. JOINT INJURIES (ANKLE / KNEE / WRIST)		
4. VISION PROBLEMS (GLASSES / CONTACTS?)			17. REQUIRED RESTRICTED PHYSICAL ACTIVITY		
5. EAR OR HEARING PROBLEMS			18. FAMILY HISTORY OF DEATH LESS THAN AGE 40		
6. SEIZURES OR CONVULSIONS			19. FAMILY HX OF HEART DISEASE/STROKE < AGE 55		
7. DIZZINESS OR FAINTING WITH EXERCISE			20. FAMILY HX OF HIGH CHOLESTEROL		
8. HEADACHES			21. FAMILY HX OF CANCER		
9. HEAD INJURY OR LOSS OF CONSCIOUSNESS			22. DENTAL OR ORTHODONTIC BRACES		
10. NECK OR BACK INJURY			23. CHICKEN POX (IF YES, DATE:)		
11. ASTHMA OR DIFFICULTY BREATHING			24. ROUTINE OR DAILY MEDICATIONS (LIST BELOW)		
12. HEART OR BLOOD PRESSURE PROBLEMS			25. FEMALES: AGE OF FIRST PERIOD:		
13. CHEST PAIN WITH EXERCISE			26. OTHER PROBLEMS (LIST BELOW):		

IF YOU ANSWER YES TO ANY OF THE ABOVE, PLEASE EXPLAIN:

I GIVE PERMISSION FOR MY CHILD TO HAVE THE FOLLOWING DONE:	YES	NO
1. RECEIVE A PPD (SKIN TEST FOR TUBERCULOSIS)		
2. RECEIVE ANY IMMUNIZATION(S) NECESSARY		
3. RECEIVE A HEALTH SCREEN EXAMINATION FOR SPORTS/SCHOOL/SCOUTS/CDS/OTHER		
4. RECEIVE EMERGENCY MEDICAL CARE DURING SCHOOL OR ORGANIZATIONAL ACTIVITIES INCLUDING CDS		

TYPED OR PRINTED NAME OF PARENT OR GUARDIAN	SIGNATURE OF PARENT OR GUARDIAN

MCEUH OP 34, May 00 (MRRC Approved: 3 May00)

MEDICAL STAFF ASSESSMENT (FILLED OUT BY PHYSICIAN ONLY)

AGE: YRS MOS	HEIGHT: cm.(%ile)	WEIGHT: kgs.(%ile)	BP: / P
	HEIGHT: in.	WEIGHT: lbs.	

VISUAL ACUITY: RIGHT /LEFT /TESTED WITH / WITHOUT LENSES NORMAL ☐ ABNORMAL ☐

	NORMAL	ABNORMAL	N/A	COMMENTS
1. EYES				
2. EARS, NOSE & THROAT				
3. HEARING				
4. MOUTH AND TEETH				
5. NECK (SOFT TISSUES)				
6. CARDIOVASCULAR				
7. CHEST AND LUNGS				
8. ABDOMEN				
9. GENITALIA - HERNIA				
10. SKIN AND LYMPHATICS				
11. NECK				
12. SPINE - SCOLIOSIS				
13. EXTREMITES				
14. NEUROLOGICAL				

15. SEXUAL MATURITY RATING: BREASTS> PUBIC HAIR> MALE GENITAL> FEMALE GENITAL>

BASED ON THIS HX & PX EXAM, THE FOLLOWING ABORMALITIES WERE FOUND AND MAY NEED TREATMENT:

ANTICIPATORY GUIDANCE (CHECK ITEMS DISCUSSED)

☐	NUTRITION	☐	DENTAL CARE	☐	HEADSS	☐	
☐	AGE APPROPRIATE SAFETY	☐	BEHAVIOR				
☐	DEVELOPMENT	☐	RISK FACTORS				

PARTICIPATION RECOMMENDATIONS

☐ NORMAL SCHOOL ACTIVITIES INCLUDING PE

☐ CHILD DEVELOPMENT / YOUTH SERVICES

☐ COLLISION SPORTS

☐ CONTACT SPORTS

☐ NON-CONTACT SPORTS

☐ SCOUTS

THIS STUDENT HAS HEALTH PROBLEMS WHICH WOULD PROHIBIT HIM OR HER FROM PARTICIPATING IN COMPETITIVE ATHLETICS:

☐ NO

☐ YES

THE FOLLOWING HEALTH PROBLEMS SHOULD BE EVALUATED OR TREATED PRIOR TO PARTICIPATING IN COMPETITIVE SPORTS:

THIS DOCUMENT IS VALID FOR 1 YEAR FROM DATE INDICATED BELOW

DATE PHYSICIAN STAMP PHYSICIAN SIGNATURE