DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
STUDENT HEALTH HISTORY

PRIVACY ACT STATEMENT:

AUTHORITY: 10 U.S.C. sections 2164 and 20 U.S.C. sections 921-932.
PRINCIPAL PURPOSE: To obtain health information about a student enrolling in Department of Defense Education Activity (DoDEA) schools and programs to protect and enhance student health and to promote a safe school environment.
ROUTINE USES: DoDEA may release information without prior consent within the DoD when needed to perform an official DoD duty, in accordance with 5 U.S.C. section 552a(b)(1). DoDEA also may release information outside the DoD, in accordance with 5 U.S.C. section 552a(b)(2-12), and the "Blanket Routine Uses," published at http://www.defenselink.mil/privacy/notice/osd. Examples of release may include 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.

NAME (*Last, First, Middle Initial*)	Check: ☐ Female ☐ Male	Date of Birth: _____/_____/_____ (mm / dd / yyyy)

MEDICAL HISTORY: CHECK (✓) ALL THAT APPLY AND EXPLAIN BELOW OR ATTACH ADDITIONAL PAGE(S).

	VISION
	Wears glasses for reading
	Wears glasses full time
	Wears contacts
	Color deficiency
	Other
	HEARING
	Frequent ear infections
	Ear tubes Insertion date: Are tubes currently in place: Right? YES ☐ NO ☐ Left? YES ☐ NO ☐
	Hearing loss: Right ☐ Left ☐
	Other
	ENDOCRINE
	Diabetes
	Other
	DERMATOLOGY
	Eczema
	Other
	GENITOURINARY
	Bladder control problems
	Urinary track infections
	Other

	RESPIRATORY
	Bronchitis
	Cystic fibrosis
	Sinusitis
	Other
	CARDIOVASCULAR
	Sickle cell disorder
	Heart murmur
	Hemophilia/Other Bleeding disorders
	Rheumatoid heart disease
	Other
	MUSCULOSKELETAL
	Muscular Dystrophy
	Scoliosis
	Other
	GASTROINTESTINAL
	Hernia
	Other
	DENTAL
	Braces
	Other

ASTHMA

Date of Diagnosis:

Inhaler needed:
@ school * YES ☐ NO ☐
@ home YES ☐ NO ☐

	PSYCHIATRY
	Anorexia
	Bulimia
	Autism
	ADD/ADHD
	Depression
	Substance abuse history
	Suicidal
	Other
	NEUROLOGICAL
	Cerebral Palsy
	Frequent headaches
	Migraines
	Spina Bifida
	Seizures
	Sleep disorder
	Other

	ALLERGIES (A SHSG Form H-3-7 should be completed.)
	Bee sting
	Wasp sting
	Other insects
	Seasonal
	Environmental
	Food
	Lactose intolerance (The school will need a letter from the doctor stating that the student is lactose intolerant.)
	PROCEDURES: (A SHSG Form H-4-9 should be completed.)
	My child will/may require special health care procedures during the school day. (See page 2.)
	RESTRICTIONS
	My child has a condition that warrants restriction of activities during school hours. (See page 2)
	My child takes daily medication at home.
	My child will need medications during school hours. (* See page 2.)
	My child may need emergency medications during school hours. (* See page 2.)

*** MEDICATIONS DURING SCHOOL HOURS:** SHSG: H-3-2, 3-3 and/or 3-8 forms must be signed by the physician and a parent; and must accompany prescribed medications that are to be given during school hours. The medication will be in the original container properly labeled by the physician or pharmacy. All medications will remain at school for the duration of the prescription.

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Explain any of the above here or attach additional pages.

Identify any special health care procedures that your child may require during the school day:

Identify any condition that warrants a restriction of student activity, specify the nature and duration of the limitation and any other information that would help the school assist your child:

Identify any condition that warrants daily and/or emergency administration of medicine for your child and list those medications:

Parent/Sponsor's Signature:	Primary phone #:	Date: