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** ☐ Wear Full Time ☐	SICKLE CELL DISORDER	☐	
CONTACTS	☐		ANEMIA	☐	
COLOR DEFIENCY	☐		CONGENITAL HEART	☐	
OTHER	☐		RHEUMATOID HEART	☐	
HEARING DEFECT	✓		HEART MURMUR	☐	
EAR INFECTIONS Frequency:	☐	Last Date:	RESTRICTIONS YES ☐ NO ☒		
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 ☐			BRONCHITIS	☐	
SEVERE Left ☐ Right ☐		Date Diagnosis: 03/23/1995	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: Once a day
ALLERGIES	✓	**ANA Kit Required**	SINUSITIS	☐	Frequency: Once a day
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 Date:		Explain:
MALERIA	☐		SCOLIOSIS	☐	Date Diagnosed:
PIN WORMS	☐		DEFORMITY Explain:	☐	
SCABIES	☐		HERNIA	☐	

HEAD LICE	☐		OSGOOD-SCHLATTER	☐	
NEUROLOGICAL		**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) Other	☐		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:	YES ○ NO ◉	Comments:

SPACE BELOW FOR PARENT TO PROVIDE ADDITIONAL INFORMATION CONCERNING OTHER MEDICAL CONDITIONS.
(PLEASE PRINT)

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.

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