

**DEPARTMENT OF DEFENSE DEPENDENTS SCHOOLS
SCHOOL HEALTH RECORD**

INSTRUCTIONS: 1. ANNUALLY COMPLETED BY SPONSOR/PARENT 2. PRINT ALL ENTRIES 3. CHECK (✓) ALL CONDITIONS THAT APPLY

Student #	STUDENT'S NAME	CHECK	✓	
Birth Date:	Last First	Female	<input type="checkbox"/>	
	MI	Male	<input type="checkbox"/>	

HEALTH HISTORY

VISUAL DEFECT		COMMENTS	CARDIOVASCULAR		COMMENTS
WEARS GLASSES	<input type="checkbox"/>		SICKLE CELL ANEMIA	<input type="checkbox"/>	
CONTACTS	<input type="checkbox"/>		CONGENITAL HEART	<input type="checkbox"/>	
OTHER	<input type="checkbox"/>		RHEUMATOID HEART	<input type="checkbox"/>	
MULTIPLE	<input type="checkbox"/>		HEART MURMUR		
HEARING DEFECT		COMMENTS	NO RESTRICTIONS		
MILD LOSS			RESTRICTION	<input type="checkbox"/>	
BOTH	<input type="checkbox"/>		LEUKEMIA	<input type="checkbox"/>	
RIGHT	<input type="checkbox"/>		OTHER	<input type="checkbox"/>	
LEFT	<input type="checkbox"/>		MULTIPLE	<input type="checkbox"/>	
MODERATE LOSS			RESPIRATORY		COMMENTS
BOTH	<input type="checkbox"/>		ASTHMA	<input type="checkbox"/>	
RIGHT	<input type="checkbox"/>		BRONCHITIS	<input type="checkbox"/>	
LEFT	<input type="checkbox"/>		CYSTIC FIBROSIS	<input type="checkbox"/>	
SEVERE LOSS			OTHER	<input type="checkbox"/>	
BOTH	<input type="checkbox"/>		MULTIPLE	<input type="checkbox"/>	
RIGHT	<input type="checkbox"/>		DERMATOLOGY		COMMENTS
LEFT	<input type="checkbox"/>		ACNE	<input type="checkbox"/>	
WEARS AID			ECZEMA	<input type="checkbox"/>	
BOTH	<input type="checkbox"/>		PSORIASIS	<input type="checkbox"/>	
RIGHT	<input type="checkbox"/>		OTHER	<input type="checkbox"/>	
LEFT	<input type="checkbox"/>		MULTIPLE	<input type="checkbox"/>	
TUBES IN EAR(S)	<input type="checkbox"/>	DATE: AFF. EAR:	ENDOCRINE		COMMENTS
EAR INFECTIONS	<input type="checkbox"/>		DIABETES	<input type="checkbox"/>	
OTHER	<input type="checkbox"/>		HYPERTHYROID	<input type="checkbox"/>	
MULTIPLE	<input type="checkbox"/>		HYPOTHYROID	<input type="checkbox"/>	
OTHER	<input type="checkbox"/>		OTHER	<input type="checkbox"/>	
ALLERGIES		ANA KIT:	MUSCULOSKELETAL		COMMENTS
BEE STING	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	OSTEOARTHRITIS	<input type="checkbox"/>	
DRUG	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	RHEUMATOID ARTHRITIS	<input type="checkbox"/>	
FOOD	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	MUSCULAR DYSTROPHY	<input type="checkbox"/>	
INSECT BITES	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	OSGOOD-SCHLATTER	<input type="checkbox"/>	
HAYFEVER	<input type="checkbox"/>		SCOLIOSIS	<input type="checkbox"/>	
OTHER	<input type="checkbox"/>		OTHER	<input type="checkbox"/>	
MULTIPLE	<input type="checkbox"/>				

CONTINUE ON REVERSE SIDE

HEALTH HISTORY CONTINUED

NEUROLOGY	<input checked="" type="checkbox"/>	COMMENTS	PSYCHIATRIC CONT	<input checked="" type="checkbox"/>	COMMENTS
CEREBRAL PALSY	<input type="checkbox"/>		MULTIPLE	<input type="checkbox"/>	
HEADACHE	<input type="checkbox"/>		GASTROINTESTINAL/ GENITOURINARY	<input checked="" type="checkbox"/>	
MIGRAINE	<input type="checkbox"/>		BLADDER CONTROL PROBLEM	<input type="checkbox"/>	
SEIZURE DISORDER	<input type="checkbox"/>		BOWEL CONTROL PROBLEM	<input type="checkbox"/>	
SEIZURE DISORDER HISTORY	<input type="checkbox"/>	MOST RECENT DATE: SPECIFY:	FREQUENT URINARY INFECTION	<input type="checkbox"/>	MOST RECENT DATE:
OTHER	<input type="checkbox"/>		OTHER	<input type="checkbox"/>	
MULTIPLE	<input type="checkbox"/>		MULTIPLE	<input type="checkbox"/>	
PSYCHIATRIC	<input checked="" type="checkbox"/>	COMMENTS	OTHER MEDICAL	<input checked="" type="checkbox"/>	COMMENTS
ATTENTION DEFICIT	<input type="checkbox"/>		DENTAL	<input type="checkbox"/>	
ANOREXIA	<input type="checkbox"/>		NUTRITIONAL DEFICIENCY	<input type="checkbox"/>	
BULIMIA	<input type="checkbox"/>		OBESITY	<input type="checkbox"/>	
DEPRESSION	<input type="checkbox"/>		OTHER	<input type="checkbox"/>	
OTHER	<input type="checkbox"/>		MULTIPLE	<input type="checkbox"/>	

	CHECK <input checked="" type="checkbox"/>		
	YES <input type="checkbox"/>	NO <input type="checkbox"/>	NOTES
DOES YOUR CHILD TAKE DAILY MEDICATIONS? Permission for medication form signed by a physician and a parent, 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 (<i>to include medications taken at home</i>):			
HAS YOUR CHILD BEEN HOSPITALIZED? Specify the date and reason: DATE: D ____ M ____ Y ____ REASON:			

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

HAS YOUR CHILD HAD CHICKEN POX? YES ____ NO ____ If yes, what year? _____

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 School Information 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: _____

Parent/Sponsor's Signature: _____ Date: _____

Parent/Sponsor's Signature: _____ Date: _____