

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	RESPIRATORY	ASTHMA	ALLERGIES (A SHSG Form H-3-7 should be completed.)
<input type="checkbox"/> Wears glasses for reading	<input type="checkbox"/> Bronchitis	Date of Diagnosis: Inhaler needed: @ school * YES <input type="checkbox"/> NO <input type="checkbox"/> @ home YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> Bee sting
<input type="checkbox"/> Wears glasses full time	<input type="checkbox"/> Cystic fibrosis		<input type="checkbox"/> Wasp sting
<input type="checkbox"/> Wears contacts	<input type="checkbox"/> Sinusitis		<input type="checkbox"/> Other insects
<input type="checkbox"/> Color deficiency	<input type="checkbox"/> Other		<input type="checkbox"/> Seasonal
<input type="checkbox"/> Other	CARDIOVASCULAR		<input type="checkbox"/> Environmental
HEARING	<input type="checkbox"/> Sickle cell disorder	PSYCHIATRY	<input type="checkbox"/> Food
<input type="checkbox"/> Frequent ear infections	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Anorexia	<input type="checkbox"/> Lactose intolerance (The school will need a letter from the doctor stating that the student is lactose intolerant.)
<input type="checkbox"/> Ear tubes Insertion date: Are tubes currently in place: Right? YES <input type="checkbox"/> NO <input type="checkbox"/> Left? YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> Hemophilia/Other Bleeding disorders	<input type="checkbox"/> Bulimia	
<input type="checkbox"/> Hearing loss: Right <input type="checkbox"/> Left <input type="checkbox"/>	<input type="checkbox"/> Rheumatoid heart disease	<input type="checkbox"/> Autism	PROCEDURES: (A SHSG Form H-4-9 should be completed.)
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> My child will/may require special health care procedures during the school day. (See page 2.)
ENDOCRINE	MUSCULOSKELETAL	<input type="checkbox"/> Depression	RESTRICTIONS
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Substance abuse history	<input type="checkbox"/> My child has a condition that warrants restriction of activities during school hours. (See page 2)
<input type="checkbox"/> Other	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Suicidal	
DERMATOLOGY	<input type="checkbox"/> Other	NEUROLOGICAL	<input type="checkbox"/> My child takes daily medication at home.
<input type="checkbox"/> Eczema	GASTROINTESTINAL	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> My child will need medications during school hours. (* See page 2.)
<input type="checkbox"/> Other	<input type="checkbox"/> Hernia	<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> My child may need emergency medications during school hours. (* See page 2.)
GENITOURINARY	<input type="checkbox"/> Other	<input type="checkbox"/> Migraines	
<input type="checkbox"/> Bladder control problems	DENTAL	<input type="checkbox"/> Spina Bifida	* 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.
<input type="checkbox"/> Urinary track infections	<input type="checkbox"/> Braces	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Sleep disorder	
		<input type="checkbox"/> Other	

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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: