

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	<input checked="" type="checkbox"/>
Birth Date:	Last	Female	<input type="checkbox"/>
	MI	Male	<input type="checkbox"/>
	First		

**HEALTH HISTORY**

VISUAL DEFECT	CODE	✓	COMMENTS	CARDIOVASCULAR	CODE	✓	COMMENTS
WEARS GLASSES	GL	<input type="checkbox"/>		SICKLE CELL ANEMIA	ANSC	<input type="checkbox"/>	
CONTACTS	CONT	<input type="checkbox"/>		CONGENITAL HEART	HDC	<input type="checkbox"/>	
OTHER	OTH	<input type="checkbox"/>		RHEUMATOID HEART	HDR	<input type="checkbox"/>	
MULTIPLE	MULT	<input type="checkbox"/>		HEART MURMUR			
HEARING DEFECT	CODE	✓	COMMENTS	NO RESTRICTIONS	HMNR	<input type="checkbox"/>	
MILD LOSS				RESTRICTION	HMR	<input type="checkbox"/>	
BOTH	LIB	<input type="checkbox"/>		LEUKEMIA	LK	<input type="checkbox"/>	
RIGHT	LIR	<input type="checkbox"/>		OTHER	OTH	<input type="checkbox"/>	
LEFT	LIL	<input type="checkbox"/>		MULTIPLE	MULT	<input type="checkbox"/>	
MODERATE LOSS				RESPIRATORY	CODE	✓	COMMENTS
BOTH	LMB	<input type="checkbox"/>		ASTHMA	ASTH	<input type="checkbox"/>	
RIGHT	LMR	<input type="checkbox"/>		BRONCHITIS	BRON	<input type="checkbox"/>	
LEFT	LLB	<input type="checkbox"/>		CYSTIC FIBROSIS	CF	<input type="checkbox"/>	
SEVERE LOSS				OTHER	OTHER	<input type="checkbox"/>	
BOTH	LSB	<input type="checkbox"/>		MULTIPLE	MULT	<input type="checkbox"/>	
RIGHT	LSR	<input type="checkbox"/>		DERMATOLOGY	CODE	✓	COMMENTS
LEFT	LSL	<input type="checkbox"/>		ACNE	ACNE	<input type="checkbox"/>	
WEARS AID				ECZEMA	ECZ	<input type="checkbox"/>	
BOTH	AB	<input type="checkbox"/>		PSORIASIS	PSOR	<input type="checkbox"/>	
RIGHT	AR	<input type="checkbox"/>		OTHER	OTHER	<input type="checkbox"/>	
LEFT	AL	<input type="checkbox"/>		MULTIPLE	MULT	<input type="checkbox"/>	
TUBES IN EAR(S)	PET	<input type="checkbox"/>	DATE: AFF. EAR:	ENDOCRINE	CODE	✓	COMMENTS
EAR INFECTIONS	OTMC	<input type="checkbox"/>		DIABETES	DM	<input type="checkbox"/>	
OTHER	OTH	<input type="checkbox"/>		HYPERTHYROID	THHI	<input type="checkbox"/>	
MULTIPLE	MULT	<input type="checkbox"/>		HYPOTHYROID	THLO	<input type="checkbox"/>	
ALLERGIES	CODE	✓	ANA KIT:	OTHER	OTH	<input type="checkbox"/>	
BEE STING	BEE	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	MUSCULOSKELETAL	CODE	✓	COMMENTS
DRUG	DRUG	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	OSTEOARTHRITIS	AO	<input type="checkbox"/>	
FOOD	FOOD	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	RHEUMATOID ARTHRITIS	AR	<input type="checkbox"/>	
INSECT BITES	INS	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	MUSCULAR DYSTROPHY	MD	<input type="checkbox"/>	
HAYFEVER	HAY	<input type="checkbox"/>		OSGOOD-SCHLATTER	OS	<input type="checkbox"/>	
OTHER	OTH	<input type="checkbox"/>		SCOLIOSIS	SC	<input type="checkbox"/>	
MULTIPLE	MULT	<input type="checkbox"/>		OTHER	OTH	<input type="checkbox"/>	

CONTINUE ON REVERSE SIDE

**HEALTH HISTORY CONTINUED**

NEUROLOGY	CODE	✓	COMMENTS	PSYCHIATRIC CONT	CODE	✓	COMMENTS
CEREBRAL PALSY	CP	<input type="checkbox"/>		MULTIPLE	MULT	<input type="checkbox"/>	
HEADACHE	HA	<input type="checkbox"/>		GU/GI	CODE	<input checked="" type="checkbox"/>	
MIGRAINE	HAM	<input type="checkbox"/>		BLADDER CONTROL PROBLEM	INC	<input type="checkbox"/>	
SEIZURE DISORDER	SD	<input type="checkbox"/>		BOWEL CONTROL PROBLEM	INC	<input type="checkbox"/>	
SEIZURE DISORDER HISTORY	SDH	<input type="checkbox"/>	MOST RECENT DATE: SPECIFY:	FREQUENT URINARY INFECTION	UTI	<input type="checkbox"/>	MOST RECENT DATE:
OTHER	OTH	<input type="checkbox"/>		OTHER	OTH	<input type="checkbox"/>	
MULTIPLE	MULT	<input type="checkbox"/>		MULTIPLE	MULT	<input type="checkbox"/>	
PSYCHIATRIC	CODE	✓	COMMENTS	OTHER MEDICAL	CODE	✓	COMMENTS
ATTENTION DEFICIT	ADD	<input type="checkbox"/>		DENTAL	DENT	<input type="checkbox"/>	
ANOREXIA	ANOR	<input type="checkbox"/>		NUTRITIONAL DEFICIENCY	NUID	<input type="checkbox"/>	
BULIMIA	BUL	<input type="checkbox"/>		OBESITY	OBES	<input type="checkbox"/>	
DEPRESSION	DEPR	<input type="checkbox"/>		OTHER	OTH	<input type="checkbox"/>	
OTHER	OTH	<input type="checkbox"/>		MULTIPLE	MULT	<input type="checkbox"/>	

CHECK		✓	NOTES	
<b>DOES YOUR CHILD TAKE DAILY MEDICATIONS?</b> 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 (to include medications taken at home):		YES <input type="checkbox"/>	NO <input type="checkbox"/>	NOTES
<b>HAS YOUR CHILD BEEN HOSPITALIZED? Specify the date and reason:</b> DATE: D ____ M ____ Y ____ REASON:		YES <input type="checkbox"/>	NO <input type="checkbox"/>	NOTES

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

**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: \_\_\_\_\_