

H-1-1	DEPARTMENT OF DEFENSE EDUCATION ACTIVITY STUDENT HEALTH HISTORY
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The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (0704-0495). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. RETURN COMPLETED FORM TO THE SCHOOL IN WHICH THE STUDENT IS ENROLLING.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. section, 2164 (Department of Defense Domestic Dependent Elementary and Secondary Schools) and 20 U.S.C. sections 921-932 (Defense dependents' education system).
PRINCIPAL PURPOSE: Obtain health related information about a student enrolling or enrolled in Department of Defense Education Activity (DoDEA) schools and programs to protect and enhance student health and promote a safe school environment. Determine services to be provided for a student in an equal opportunity to participate in public education.
ROUTINE USES: DoDEA may release information without prior consent within the Department of Defense (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://dpcid.defense.gov/Privacy/SORNsindex/BlanketRoutineUses.aspx>. Examples of release may include for valid medical, law enforcement or security purposes or for use in litigation involving the DoD.
DISCLOSURE: Voluntary. However, failure to provide the requested information may result in the delay or denial of student services.

NAME of Student _____ Grade _____	Check: Female Male	Date of Birth: ____/____/____ (mm / dd / yyyy)
Last First Middle Initial		

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

ALLERGIES	RESPIRATORY	PSYCHOSOCIAL	Please provide additional information if needed to ensure your dependent's welfare and safety during school days. Attach an additional page if needed. Contact the school nurse for any health concerns regarding your dependent.
Insect sting (bee/wasp/ant)	Asthma	ADHD date diagnosed:	
Drug/Medication*	Date diagnosed:	Anxiety date diagnosed:	
Environmental	Inhaler needed: Yes No	Autism	
Food*	@ school: Yes No	Depression	
Seasonal	@ home: Yes No	Eating disorder	
Other:	Bronchitis	Self-harm / cutting	
*Name allergen:	Cystic fibrosis	Suicidal thoughts / attempt	
	Pneumonia		
EYES	CARDIOVASCULAR	MEDICATION	
Glasses/contact lenses	Sinusitis	* My dependent will need medications during school hours for the treatment of _____.	
Wears glasses full time	TB		
Glasses for reading	Other:	* My dependent may need emergency medication during school hours for _____.	
Color deficiency	Congenital heart defect Needs special care: Yes No	Identify any condition that warrants daily, as needed, and/or emergency administration of medicine for your dependent and list all medications: _____	
Other:	Specify care:		
EARS	Enlarged heart	* Please see the school nurse for information regarding medication at school. Certain forms (H-3-2 and/or H-3-9) need to be signed by prescribing Primary Care Manager (PCM)/doctor and sponsor/parent/guardian. All medications will be in the original container and pharmacy label with the student's name. Medications will remain at school for the duration of the treatment/prescription.	
Frequent ear infections	Heart murmur		
Hearing loss Right Left	Rheumatic heart disease		
Hearing aid Right Left	Hemophilia		
Ear tubes	Sickle cell disorder		
Date placed:	Hypercholesterolemia		
Right/Left/Both:	High blood pressure		
Other:	Other:		
DENTAL	GASTROINTESTINAL	Health Care Treatment, Restrictions	
Braces	Frequent constipation	Identify any special health care procedures that your dependent may require during the school day:	
Other:	Irritable bowel syndrome (IBS)		
NEUROLOGIC	Hernia		
Cerebral palsy	Lactose intolerant **		
Concussion	Other:		
Frequent headaches	MUSCULOSKELETAL	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 dependent:	
Migraine	Muscular dystrophy		
Seizure	Scoliosis		
Spina bifida	Other:		
Sleep disorder	GENITOURINARY		
Other:	Bladder control problem		
ENDOCRINE	Intermittent catheterization	** Lactose Intolerant	
Diabetes	Self cath. / needs help	A written note is required from the PCM/doctor stating that student is lactose intolerant.	
Thyroid	Needs frequent bathroom use		
Other:	Urinary tract infections		
SKIN/DERMATOLOGY	Other:		
Acne	**Enter your name below. This is a legally binding electronic signature that confirms all information provided here is complete and accurate to the best of your knowledge.		
Eczema			
Ingrown toe nail			
Other:			
Sponsor/Parent/Guardian's Name		Date	
		Primary Phone No.	