H-1-1

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
STUDENT HEALTH HISTORY

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://dpcld.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 ____
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).

ALLERGIES
- ☐ Insect sting (bee/wasp/ant)
- ☐ Drug/Medication*
- ☐ Environmental
- ☐ Food*
- ☐ Seasonal
- ☐ Other:
- ☐ *Name allergen:

EYES
- ☐ Glasses/contact lenses
- ☐ Wears glasses full time
- ☐ Glasses for reading
- ☐ Color deficiency
- ☐ Other:

EARS
- ☐ Frequent ear infections
- ☐ Hearing loss ☐ Right ☐ Left
- ☐ Hearing aid ☐ Right ☐ Left
- ☐ Ear tubes
  Date placed:
  Right/Left/Both:
- ☐ Other:

DENTAL
- ☐ Braces
- ☐ Other:

NEUROLOGIC
- ☐ Cerebral palsy
- ☐ Concussion
- ☐ Frequent headaches
- ☐ Migraine
- ☐ Seizure
- ☐ Spina bifida
- ☐ Sleep disorder
- ☐ Other:

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid
- ☐ Other:

SKIN/DERMATOLOGY
- ☐ Acne
- ☐ Eczema
- ☐ Ingrown toe nail
- ☐ Other:

RESPIRATORY
- ☐ Asthma
  Date diagnosed:
  Inhaler needed: ◯ Yes ◯ No
  @ school: ◯ Yes ◯ No
  @ home: ◯ Yes ◯ No
- ☐ Bronchitis
- ☐ Cystic fibrosis
- ☐ Pneumonia
- ☐ Sinusitis
- ☐ TB
- ☐ Other:

CARDIOVASCULAR
- ☐ Congenital heart defect Needs special care: ◯ Yes ◯ No
  Specify care:
- ☐ Enlarged heart
- ☐ Heart murmur
- ☐ Rheumatic heart disease
- ☐ Hemophilia
- ☐ Sickle cell disorder
- ☐ Hypercholesterolemia
- ☐ High blood pressure
- ☐ Other:

GASTROINTESTINAL
- ☐ Frequent constipation
- ☐ Irritable bowel syndrome (IBS)
- ☐ Hernia
- ☐ Lactose intolerant **
- ☐ Other:

MUSCULOSKELETAL
- ☐ Muscular dystrophy
- ☐ Scoliosis
- ☐ Other:

GENITOURINARY
- ☐ Bladder control problem
- ☐ Intermittent catheterization Self cath. / needs help
- ☐ Needs frequent bathroom use
- ☐ Urinary tract infections
- ☐ Other:

PSYCHOSOCIAL
- ☐ ADHD date diagnosed:
- ☐ Anxiety date diagnosed:
- ☐ Autism
- ☐ Depression
- ☐ Eating disorder
- ☐ Self-harm / cutting
- ☐ Suicidal thoughts / attempt

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.

MEDICATION

☐ * My dependent will need medications during school hours for the treatment of_____.

☐ * My dependent may need emergency medication during school hours for _____.

☐ Identify any condition that warrants daily, as needed, and/or emergency administration of medicine for your dependent and list all medications: _____
_____

* 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.

Health Care Treatment, Restrictions

Identify any special health care procedures that your dependent 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 dependent:

**** Lactose Intolerant**

A written note is required from the PCM/doctor stating that student is lactose intolerant.

***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.*

Sponsor/Parent/Guardian's Name **Date** **Primary Phone No.**