INFANT, CHILD AND ADOLESCENT HEALTH ASSESSMENT

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, United States Code, Section 3012.
PRINCIPAL PURPOSE: Information is used by DA personnel to : (1) verify child health status and currency of immunizations per admission requirements; (2) note special program considerations or restrictions on child participation; (3) execute emergency medical procedures for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program.
ROUTINE USES: No information is disclosed outside DoD.
DISCLOSURE: Disclosure of requested information is voluntary; however, if information is not provided, individuals may not be able to participate in community activity programs.

NAME OF SPONSOR	DEROS	TELEPHONE (Home)	TELEPHONE (Duty)

SPONSOR'S UNIT ADDRESS	SPONSOR'S SSAN	SPOUSE'S WORK PHONE

CHILD HEALTH INFORMATION (Sponsor)

NAME OF CHILD	BIRTH DATE	SEX

HAS YOUR CHILD BEEN UNDER REGULAR SUPERVISION OF A PHYSICIAN? (If yes, explain circumstance(s) and current status)

IS CHILD ENROLLED IN EXCEPTIONAL FAMILY MEMBER PROGRAM? NO / YES LAST UPDATE:

IMMUNIZATIONS

	DATE	DATE	DATE	DATE	DATE	DATE
POLIO						
DPT						
HIB						
VARICELA						
HEP B				HEP A→		
MMR						
PPD						

MEDICAL HISTORY

	YES	NO		YES	NO
ALLERGIES			HEAT STROKE OR EXHAUSTION		
ASTHMA			HOSPITALIZATIONS OR OPERATIONS		
BEDWETTING			JOINT INJURY (ANKEL/KNEE/WRIST)		
BROKEN BONES OR SPRAINS			NECK OR BACK INJURY		
CHICKEN POX (If yes, date)			REQUIRED RESTRICTED PHYSICAL ACTIVITY		
DIABETES			RHEUMATIC FEVER		
DIZZINESS OR FAINTING WITH EXERCISE			SCOLIOSIS		
EAR OR HEARING PROBLEMS			SEIZURES OR CONVULSIONS		
FAMILY HISTORY OF DEATH < 40 YEARS			SLEEP PROBLEMS		
FAMILY HY OF HEART DISEASE/STROKE < 55 YEARS			SPEECH PROBLEMS		
FAMILY HISTORY OF CANCER			DENTAL OR ORTHODONTIC BRACES		
FAMILY HISTORY OF HIGH CHOLESTEROL			VISION PROBLEMS (GLASSES/CONTACTS)		
HEADACHES			ROUTINE OR DAILY MEDICATIONS (List below)		
HEAD INJURY OR LOSS OF CONSCIOUSNESS			FEMALES – AGE OF FIRST PERIOD:		
HEART OR BLOOD PRESSURE PROBLEMS			OTHER PROBLEMS (List below)		

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN:

I GIVE PERMISSION FOR MY CHILD TO HAVE THE FOLLOWING DONE:	**YES**	**NO**
1. RECEIVE A PPD (SKIN TEST FOR TUBERCULOSIS)		
2. RECEIVE A HEALTH SCREEN EXAMINATION FOR SPORTS/SCHOOL/SCOUTS/CDS/OTHER		
3. RECEIVE EMERGENCY MEDICAL CARE DURING SCHOOL OR ORGANIZATIONAL ACTIVITIES INCLUDING CDS		

TYPED OR PRINTED NAME OF PARENT OR GUARDIAN	SIGNATURE OF PARENT OR GUARDIAN

MCEUH OP 34, May 00 (MRRC Approved: 3 May 00)

MEDICAL STAFF ASSESSMENT

AGE: yrs mos	HEIGHT: cm. (%ile)	WEIGHT: kgs (%ile)	BP: / P

VISUAL ACUITY: RIGHT / LEFT /	TESTED WITH / WITHOUT LENSES	NORMAL		ABNORMAL	

	NORMAL	ABNORMAL	NOT EXAMINED	COMMENTS
1. EYES				
2. EARS, NOSE & THROAT				
3. HEARING				
4. MOUTH AND TEETH				
5. NECK (SOFT TISSUES)				
6. CARDIOVASCULAR				
7. CHEST AND LUNGS				
8. ABDOMEN				
9. GENITALIA-HERNIA				
10. SKIN AND LYMPHATICS				
11. NECK				
12. SPINE - SCOLIOSIS				
13. EXTREMITIES				
14. NEUROLOGICAL				

15. SEXUAL MATURITY RATING: BREASTS> PUBIC HAIR> MALE GENITAL> FEMALE GENITAL>

BASED ON THIS HISTORY & PHYSICAL EXAM, THE FOLLOWING ABNORMALITIES WERE FOUND AND MAY NEED TREATMENT:

ANTICIPATORY GUIDANCE (CHECK ITEMS DISCUSSED)

	NUTRITION		DENTAL CARE				
	AGE APPROPRIATE SAFETY		BEHAVIOR				
	DEVELOPMENT		RISK FACTORS				

PARTICIPATION RECOMMENDATIONS

- ☐ NORMAL SCHOOL ACTIVITIES INCLUDING PE
- ☐ CHILD DEVELOPMENT / YOUTH SERVICES
- ☐ COLLISION SPORTS
- ☐ CONTACT SPORTS
- ☐ NON-CONTACT SPORTS
- ☐ SCOUTS

THIS STUDENT HAS HEALTH PROBLEMS WHICH WOULD PROHIBIT HIM OR HER FROM PARTICIPATING IN COMPETITIVE ATHLETICS: ☐ NO ☐ YES

THE FOLLOWING HEALTH PROBLEMS SHOULD BE EVALUATED OR TREATED PRIOR TO PARTICIPATING IN COMPETITIVE SPORTS:

THIS DOCUMENT IS VALID FOR 2 YEARS (For sports, valid for 1 year) FROM DATE INDICATED BELOW

DATE PHYSICIAN STAMP PHYSICIAN SIGNATURE