



# HEALTH HISTORY

PLEASE PRINT

To Be Completed By Parent/Legal Guardian Annually

Note: Your child will NOT be disqualified from the program based on information provided here.

## YOUNG MARINE INFORMATION

Last Name		First Name	Middle Initial
Age	Birthdate (MM/DD/YYYY)	Social Security Number	
Parent/Guardian Name			
Primary Physician's Name		Date of Last Visit	
Dentist's Name		Date of Last Visit	

## HEALTH HISTORY

Condition	*YES	NO	Remarks (*Yes requires remarks)
Wears eye glasses / contact lenses			
Is on a restricted diet			Specify:
Wears a hearing aid			
Diabetes			Last HbA1c percentage and date:
Is under a doctor's care			
Hypertension (high blood pressure)			
Adult or congenital heart disease / heart attack / chest pain (angina) / heart murmur / coronary artery disease / any heart surgery or procedure / suffered Rheumatic Fever. Explain all "yes" answers.			
Family history of heart disease or any sudden heart-related death of a family member before age 50.			
Stroke/ TIA			
Asthma			Last attack date:
Lung/ respiratory disease			
Ear/ eyes/ nose/ sinus problems			
Muscular/ skeletal condition/ muscle or bone issues			
Head injury/ concussion			
Psychiatric/ psychological or emotional difficulties			
Behavioral/ neurological disorders			
Blood disorders/ sickle cell disease			
Fainting spells and/ or dizziness			
Kidney Disease			
Seizures			Last seizure date:
Abdominal/ stomach/ digestive problems			
Excessive fatigue			
Thyroid Disease			
Obstructive sleep apnea/ sleep disorders			CPAP: Yes No
List all surgeries and hospitalizations			
List any other medical conditions not covered above			

## ALLERGIES

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
		Medication				Plants	
		Food				Insect stings / bites	

## IMMUNIZATION

I certify that the above named child is current on all recommended vaccines and have provided appropriate records to accompany this report OR the Immunization Exemption Request Form has been submitted.	Date of Last Tetanus Shot:
Tetanus immunization is required and must have been received within the last 10 years.	Immunization Waiver Attached: Yes No

**I certify the above health history information to be complete, correct, and true to the best of my knowledge.**

Parent or Legal Guardian Signature	Date
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