

PARENT/GUARDIAN FORM 11

_____ Cadet Name Last, First, MI

SUBJECT: Cadet Health Questionnaire

1. Please provide information relative to the general health of your child. This information is confidential and your complete and honest answers will help us to better care for and treat your child.

Acute or chronic illness

- a. Asthma Yes No
- b. Cerebral Palsy Yes No
- c. Diabetic (insulin dependent) Yes No
- d. Epilepsy Yes No
- e. Frequent colds Yes No
- f. Frequent sore throat Yes No
- g. Hyperthyroidism Yes No
- h. Hypothyroidism Yes No
- i. Allergies: Yes No

If yes, please describe; _____

- j. Cancer: Yes No

If yes, please describe; _____

- k. Heart disease: Yes No

If yes, please describe; _____

2. Has your child had any accidents that resulted in an injury such as burns, fractures, lacerations, serious falls, etc Yes No If yes, please describe: _____

3. Psychological: If you answer "yes" to any of the following questions; describe in detail and provide appropriate medical reports.

- a. Has or is your child being treated by a psychiatrist or psychologist?

Yes No Diagnosis: _____

If yes, please have treating Physician provide a letter stating nature of psychological problem, plan of care and cadets eligibility for MMA.

- b. Has your child been hospitalized for any psychological problem(s)?

Yes No Diagnosis: _____

If yes, please provide a copy of hospital discharge summary and treatment plan.

- c. Is your child currently under a psychiatrist's or psychologist's care?

___ Yes ___ No _____

4. Medications:

a. Is or has your child taken prescription drugs in the last five years? ___ Yes ___ No
If yes, you must provide details and a copy of the treating physician's orders.
Dates taken: _____

<u>Drug Description</u>	<u>Dosage</u>	<u>Reason for Treatment</u>
_____	_____	_____
_____	_____	_____

b. Is your child taking over the counter drugs (non-prescription)? ___ Yes ___ No
If yes, please provide details: _____

<u>Drug Description</u>	<u>Dosage</u>	<u>Reason for Treatment</u>
_____	_____	_____
_____	_____	_____

c. Is your child allergic to any drugs or medications? ___ Yes ___ No
If yes, identify the medications or drugs and potential reaction:

<u>Medication</u>	<u>Reaction</u>
_____	_____
_____	_____

5. Health Information:

a. General Health:

(1) Underweight or overweight for age ___ Yes ___ No

(2) Allergies related to foods: ___ Yes ___ No

Identify food and reaction _____

(3) Problems with elimination (bowel movements and/or urination) ___ Yes ___ No

If yes describe condition: _____

b. Operations:

(1) Appendectomy ___ Yes ___ No

(2) Hernia ___ Yes ___ No

(3) Tonsillectomy ___ Yes ___ No

(4) Other: ___ Yes ___ No (If yes, please describe below.)

c. Handicapping Condition(s):

- (1) Scoliosis Yes No
(2) Spinal Bifida Yes No
(3) Other: Yes No (If yes, please describe below.)
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-
-

d. Orthopedic Devices:

- (1) Wheelchair Yes No
(2) Special shoes Yes No
(3) Crutches Yes No
(4) Braces Yes No
(5) Helmet Yes No

e. Hearing Disability:

- (1) Frequent ear aches Yes No
(2) Running ear Yes No
(3) Hard of hearing Yes No
(4) Uses hearing aid Yes No

f. Communication disability:

- (1) Speech Yes No
(2) Stutters/stammers Yes No
(3) Lisps Yes No

g. Dental Concerns:

- (1) Cleft lip or palette Yes No
(2) Gum disease Yes No
(3) Wears dental braces Yes No

h. Blood Disorders:

- (1) Anemia Yes No
(2) Leukemia Yes No
(3) Hemophilia Yes No
(4) Sickle Cell Anemia Yes No

i. Vision:

- (1) Wears glasses/contacts Yes No

j. Skin and Hair:

- (1) Visible scars Yes No
(2) Hives Yes No
(3) Scabies Yes No
(4) Body Lice Yes No
(5) Head Lice Yes No

k. Mental and emotional:

- (1) Bullies others ___ Yes ___ No
- (2) Cries often ___ Yes ___ No
- (3) Lethargic (slow/lazy) ___ Yes ___ No
- (4) Short attention span ___ Yes ___ No
- (5) Very sensitive ___ Yes ___ No
- (6) Very shy ___ Yes ___ No
- (7) Wets bed ___ Yes ___ No
- (8) Depressed ___ Yes ___ No
- (9) Generally happy ___ Yes ___ No

6. Indicate any other health condition(s) your child has that are not listed on this form:

7. I have accurately disclosed and described my child's health conditions and understand that my failure to completely and accurately disclose his/her medical conditions may lead to his/her dismissal.

Parent Signature

Date