

Health History (Completed by Parent/Legal Guardian)

PLEASE PRINT (Update Annually)

Note: For the safety and well being of your child ensure all information is true and correct. Your child will NOT be disqualified from the program based on information provided here.

Last Name _____ First Name _____ Middle Initial _____
 Age _____ Date of Birth ___/___/___ Social Security Number _____
 Parent/Guardian Name _____
 Home Number (____) _____ Work Number (____) _____
 Physician's Name _____ Date of Last Visit _____
 Dentist's Name _____ Date of Last Visit _____

The Subject Young Marine:	*Yes	No	Remarks ("Yes" require remarks)
Wears Eye Glasses /Contact Lenses			
Is on a restricted diet			
Wears a hearing aid			
Visited the Dentist in the last 6 months			
Has known health problems (knee problems, migraines, etc.)			
Is under a doctors care			
Is on prescription medication			
*Has Allergies Food//Medication//Environmental (pollen, bee stings)			
Has heart murmur Suffered Rheumatic Fever Had a family member under age 50 die of a heart problem			
Suffers one or more of the following conditions: Seizures, Diabetes, Asthma, Arthritis			
Has had a history of head injury			
Has been hospitalized or had surgery and dates			
Had any injuries (no matter how minor) in the past year. (Sprains, broken bones, ingrown toenails, stitches)			
Date of last Tetanus Shot			

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

Parent/Legal Guardian _____ Date _____