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			
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			
Have a history of head injury			
Been hospitalized or had surgery and dates			
Had any injuries (no matter how minor) in the past year. (Sprains, broken bones, ingrown toenails, stitches)			
Received a Tetanus Booster and Date			

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

Parent/Legal Guardian _______________________________ Date ___________

(YMMEDFORM3)