

**DEPARTMENT OF DEFENSE EDUCATION ACTIVITY**  
**EDUCATIONAL PRE-SCREENING QUESTIONNAIRE**

STUDENT'S NAME \_\_\_\_\_ GRADE \_\_\_\_\_  Male  Female

Sponsor's Name \_\_\_\_\_ Phone: \_\_\_\_\_ / \_\_\_\_\_  
Duty Home

**PRIVACY ACT STATEMENT**

**AUTHORITY:** 10 U.S.C. 2164, 20 U.S.C. 921-932; and DoD Directive 1342.20

**PRINCIPAL PURPOSE:** The information will be used within the Department of Defense (DoD) Education Activity and DoD to determine Educational programs and interventions required to meet individual student needs. This includes programs identified for students receiving gifted education, special education, 504-disability or at risk services.

**ROUTINES USE(S):** In addition to the disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, this record or information contained therein may be disclosed outside the DoD as a routine use pursuant to 5 USC 552a(b)(3) and the DoD "Blanket Routine Uses," described at the beginning of the Office of the Secretary, DoD/Joint Staff compilation of systems of records notices, located at: <http://www.defenselink.mil/privacy/notice/osd>.

**DISCLOSURE:** Disclosure to the DoD of the information requested on this form is voluntary; but failure to provide all requested information may result in the delay or denial of student services.

*To better understand the educational needs of your child, please complete and return this in a sealed envelope marked "confidential" to the school principal or protected mail attachment. Sponsors or parents are asked to answer all questions and sign the form.*

1. Gifted Education:

- a. Has your child been formally assessed for Gifted Education:  Yes  No  
b. My child was found eligible:  Yes  No

2. At Risk Services:

- Did your child attend Sure Start or Head Start?  Yes  No  
Has your child received remedial reading services?  Yes  No  
Has your child received remedial math services?  Yes  No

3. Individual Education Program (IEP):

- a. Has your child been previously assessed:  Yes  No  
b. My child has an active IEP:  Yes  No

4. Exceptional Family Member Program (EFMP):

- My child is eligible/enrolled in EFMP  Yes  No

5. My child previously received educational assistance or accommodations in a 504 Plan (*non-special education assistance*).  Yes  No

- My child has a 504 Plan:  Yes  No

\_\_\_\_\_  
Sponsor's Signature

\_\_\_\_\_  
Date (MMDDYYYY)



## **Terms and Conditions**

### **I. Acceptable Use**

- A. I agree to use DoDEA's computer services only in support of my education and research consistent with the educational objectives of the DoDEA. I will not download files or subscribe to bulletin boards that are not related to my educational activities. If I have questions about my computer use, I will ask my teacher.
- B. I will respect and adhere to all of the rules governing access to DoDEA computing resources and the rules of any other network or computing resource to which I have access through the DoDEA equipment.
- C. I understand transmission (sent or received) of any material in violation of any U.S. or state regulation is strictly prohibited and may violate criminal law. I will not transmit obscene, sexually suggestive or offensive, lascivious, harassing, or abusive messages, copyrighted material, or material protected by trademark or as a trade secret.
- D. I will not publish the name, photograph, home address or telephone number of myself, another student, faculty, or any other person.
- E. I understand using the DoDEA computer equipment for commercial, product advertisement or political lobbying is prohibited and may be illegal.

### **II. Privileges**

- A. I understand that the use of the network is a privilege, not a right, and use inconsistent with these Terms and Conditions may result in a cancellation of those privileges. (Each student will receive instruction regarding the terms and protocols referenced in this document before network access is provided.)
- B. I will be disciplined if I send messages or download files inconsistent with these Terms and Conditions. At the discretion of the principal and teacher, I may lose the privilege of using the Internet permanently and face suspension or expulsion. Copies of the inappropriate materials will be reported to the building administration and kept on file.

### **III. Internet Etiquette**

- A. I will be polite. I will not use sexual or abusive language in my messages to others.
- B. I will use courteous, respectful language. I will not swear, use vulgarities, sexual, harsh, or disrespectful language. Illegal activities are strictly forbidden.
- C. I understand any transmission, including electronic mail, is not private and that my communications and access will be monitored.
- D. I will evaluate information carefully. As with any research material, I must review it for accuracy and bias.
- E. I will not use the network in such a way as to disrupt the use of the network by other users. This can be avoided by not sending "chain letters," or "broadcast" messages to lists or individuals.

### **IV. No Warranties**

- A. I understand DoDEA makes no warranties of any kind, whether expressed or implied, for the service it is providing. DoDEA is not responsible for any damages I may suffer. This includes loss of data, delays, non-deliveries, misdeliveries, or service interruptions caused by its own negligence or my errors or omissions.
- B. I understand the use of any information obtained via DoDEA is at my own risk. DoDEA specifically denies any responsibility for the accuracy or quality of information obtained through its services.
- C. I understand DoDEA has no obligation or authority to defend me against any legal actions brought against me by anyone arising from my misuse of DoDEA computer resources or violations of any U.S. or foreign laws.

### **V. Security**

- A. I understand security on any computer system is a high priority, especially when the system involves many users. I will notify my teacher if I notice a security problem. I will not demonstrate the problem to other users.
- B. I will not give my user password to other individuals. Any activity associated with my account will be considered my activity. It is my responsibility to protect my account and password.
- C. I may be denied access to the network if I am identified as a security risk.

### **VI. Vandalism**

- A. I understand vandalism will result in cancellation of privileges.
- B. I will not maliciously attempt to harm or destroy data of another user, Internet, or any other network. This includes, but is not limited to, the uploading or creation of computer viruses.

DEPARTMENT OF DEFENSE DEPENDENT SCHOOLS  
KAISERSLAUTERN DISTRICT OFFICE  
UNIT 3405  
APO AE 09021

**MEDICAL AUTHORIZATION SY2013-14**

STUDENT INFORMATION:

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Known Allergies and/or Conditions:

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PARENTAL AUTHORIZATION:

I \_\_\_\_\_,

authorize and execute consent for any and all emergency medical, hospital and dental care treatment, if I cannot be contact; including major surgery as deemed necessary by a duly licensed physician selected by DODDS school faculty member, for the health and well being of my child.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THIS AUTHORIZATION SHALL TERMINATE AFTER JUNE 15, 2014.**

**PRIVACY ACT STATEMENT**

Disclosure of health information will expedite the medical treatment process if it becomes necessary.  
For Official Use Only - Privacy Act of 1974.

## DEPARTMENT OF DEFENSE EDUCATION ACTIVITY STUDENT HEALTH HISTORY

**PRIVACY ACT STATEMENT:**

**AUTHORITY:** 10 U.S.C. sections 2164 and 20 U.S.C. sections 921-932.

**PRINCIPAL PURPOSE:** To obtain health information about a student enrolling in Department of Defense Education Activity (DoDEA) schools and programs to protect and enhance student health and to promote a safe school environment.

**ROUTINE USES:** DoDEA may release information without prior consent within the DoD when needed to perform an official DoD duty, in accordance with 5 U.S.C. section 552a(b)(1). DoDEA also may release information outside the DoD, in accordance with 5 U.S.C. section 552a(b)(2-12), and the "Blanket Routine Uses," published at <http://www.defenselink.mil/privacy/notice/osd>. Examples of release may include for valid medical, law enforcement or security purposes, or for use in litigation involving the DoD.

**DISCLOSURE:** Disclosure to the Agency of the information requested on this form is voluntary; but failure to provide all requested information may result in the delay or denial of student services.

**NAME** (*Last, First, Middle Initial*)

Check:

Female  
 Male

Date of Birth:

\_\_\_\_/\_\_\_\_/\_\_\_\_  
(mm / dd / yyyy)

**MEDICAL HISTORY: CHECK (✓) ALL THAT APPLY AND EXPLAIN BELOW OR ATTACH ADDITIONAL PAGE(S).**

VISION	RESPIRATORY	ASTHMA	ALLERGIES (A SHSG Form H-3-7 should be completed.)
<input type="checkbox"/> Wears glasses for reading	<input type="checkbox"/> Bronchitis	<b>Date of Diagnosis:</b>  <b>Inhaler needed:</b> @ school * YES <input type="checkbox"/> NO <input type="checkbox"/> @ home YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> Bee sting
<input type="checkbox"/> Wears glasses full time	<input type="checkbox"/> Cystic fibrosis		<input type="checkbox"/> Wasp sting
<input type="checkbox"/> Wears contacts	<input type="checkbox"/> Sinusitis		<input type="checkbox"/> Other insects
<input type="checkbox"/> Color deficiency	<input type="checkbox"/> Other		<input type="checkbox"/> Seasonal
<input type="checkbox"/> Other	CARDIOVASCULAR		<input type="checkbox"/> Environmental
HEARING	<input type="checkbox"/> Sickle cell disorder	PSYCHIATRY	<input type="checkbox"/> Food
<input type="checkbox"/> Frequent ear infections	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Anorexia	<input type="checkbox"/> Lactose intolerance (The school will need a letter from the doctor stating that the student is lactose intolerant.)
<input type="checkbox"/> Ear tubes Insertion date: Are tubes currently in place: Right? YES <input type="checkbox"/> NO <input type="checkbox"/> Left? YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> Hemophilia/Other Bleeding disorders	<input type="checkbox"/> Bulimia	<b>PROCEDURES:</b> (A SHSG Form H-4-9 should be completed.)
		<input type="checkbox"/> Autism	
<input type="checkbox"/> Hearing loss: Right <input type="checkbox"/> Left <input type="checkbox"/>	<input type="checkbox"/> Rheumatoid heart disease	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> My child will/may require special health care procedures during the school day. (See page 2.)
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Depression	RESTRICTIONS
ENDOCRINE	MUSCULOSKELETAL	<input type="checkbox"/> Substance abuse history	<input type="checkbox"/> My child has a condition that warrants restriction of activities during school hours. (See page 2.)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Suicidal	
<input type="checkbox"/> Other	<input type="checkbox"/> Scoliosis	NEUROLOGICAL	<input type="checkbox"/> My child takes daily medication at home.
DERMATOLOGY	<input type="checkbox"/> Other	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> My child will need medications during school hours. (* See page 2.)
<input type="checkbox"/> Eczema	GASTROINTESTINAL	<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> My child may need emergency medications during school hours. (* See page 2.)
<input type="checkbox"/> Other	<input type="checkbox"/> Hernia	<input type="checkbox"/> Migraines	
GENITOURINARY	<input type="checkbox"/> Other	<input type="checkbox"/> Spina Bifida	<b>* MEDICATIONS DURING SCHOOL HOURS:</b> SHSG: H-3-2, 3-3 and/or 3-8 forms must be signed by the physician and a parent; and must accompany prescribed medications that are to be given during school hours. The medication will be in the original container properly labeled by the physician or pharmacy. All medications will remain at school for the duration of the prescription.
<input type="checkbox"/> Bladder control problems	DENTAL	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Urinary track infections	<input type="checkbox"/> Braces	<input type="checkbox"/> Sleep disorder	
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other	

**DEPARTMENT OF DEFENSE EDUCATION ACTIVITY  
STUDENT HEALTH HISTORY**

**Explain any of the above here or attach additional pages.**

**Identify any special health care procedures that your child may require during the school day:**

**Identify any condition that warrants a restriction of student activity, specify the nature and duration of the limitation and any other information that would help the school assist your child:**

**Identify any condition that warrants daily and/or emergency administration of medicine for your child and list those medications:**

**Parent/Sponsor's Signature:**

**Primary phone #:**

**Date:**