HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

Dependent Medical and Educational Clearance for PCS Travel or Command Sponsorship

PART I (Completed by Sponsor and Adult Family Member)

Reason for this request: 1. PCS _____ Overseas Clearance _____ Special Needs Condition (Q-code)
2. Command Sponsorship _____ Marriage _____ Adoption ____ Other (explain)

Does this family member currently have or have a history of:

Asthma, reactive airway disease, or recurrent wheezing	YES	NO
Visits to any specialist other than a primary care provider	YES	NO
Visits to an Emergency Room or admission to a hospital in the past 5 years	YES	NO
Visits to a mental health provider, psychiatric hospitalization, or suicide attempt	YES	NO
Depression, personality disorder, anxiety, or any other mental health diagnosis	YES	NO
Medication use for a mental health diagnosis including any antidepressant	YES	NO
Misconduct at school or involving law enforcement	YES	NO
Last visiting a dentist more than 12 months ago (if over age 2)	YES	NO
Requiring further dental treatment	YES	NO
An Individualized Education Plan (IEP)	YES	NO

Explain any positive response:

List medications used in the past year other than over the counter drugs:

I certify that I have read and understand the previous instructions and that those entries made by me are true, complete, and correct to the best of my knowledge and belief. I understand that I must inform the Special Needs Coordinator of any changes to health prior to travel of family members. I understand that insufficient and/or inaccurate information may affect family member travel. I understand that a knowing and willful false statement on this form can be punishable by fine or imprisonment. (See U.S. Code, Title 18, Section 1001; Title 10, Section 907; Article 107 UCMJ.)

For overseas clearance or command sponsorship: If all relevant information is not disclosed, I also agree to apply for an early return of dependent (ERD) if requested by the military treatment facility and/or to authorize my commander to request an ERD.

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Signature of Sponsor Signature of Adult Family Member

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT:	**18th Medical Group Kadena AB, Japan**		
PATIENT'S NAME ***(Last, First, Middle initial)***			**SEX**
RELATIONSHIP TO SPONSOR:	**STATUS**		**RANK/GRADE**
SPONSOR'S NAME		**ORGANIZATION**	
DEPART./SERVICE **USAF**	**SSN/IDENTIFICATION NO.**		**DATE OF BIRTH**

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	PART II (Also complete Section V of AF Form 1466 and ensure completion of any needed DD Form 2792)
	Does this family member have any medical needs that exceed the scope of practice of a family medicine physician? YES NO
	Clarify any positive answers in Part I or Part II:

	Signature of Medical Provider
	PART III (Also complete Section VI of AF Form 1466)
	Does this family member (or sponsor) have any:
	Marital problems requiring counseling? YES NO
	Alcohol/Drug Abuse problems or history? YES NO
	Hx of misconduct at school or involving law enforcement? YES NO
	Family Advocacy investigations (past or present)? YES NO
	Past psychiatric hospitalization or suicide attempts? YES NO
	Mental health treatment (past or present)? YES NO
	Inability to converse fluently in English? YES NO
	Special needs identified? (Q-code if appropriate) YES NO
	Clarify any positive answers in Part I or Part III:

	Signature of Special Needs Coordinator