HS0058
Rev. 7/13

COMMUNITY ACTION PLAN
Health Services Department
Lincoln Public Schools

Student: _____ ID#: _____ Grade: _____ DOB: _____

Home Address: _____ Lives with: _____

Parent: _____ Phone (h): _____ (w): _____ (c): _____

Parent: _____ Phone (h): _____ (w): _____ (c): _____

Emergency Contact - if both parents are unavailable or student is own guardian:

Name/Relationship: _____ Phone (h): _____ (w): _____ (c): _____

Diabetes Plan: ☐ No ☐ Yes (explain): _____

Seizure Action Plan: ☐ No ☐ Yes (explain): _____

Allergies/Anaphalaxis: ☐ No ☐ Yes (explain): _____

Asthma Action Plan: ☐ No ☐ Yes (explain): _____

Medical Diagnosis:

Current Medications:

Name of Med	Dosage	Time of Dose	Taken at School
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Physician Information:

Name: _____ Addresses: _____ Phone: _____

Name: _____ Addresses: _____ Phone: _____

Hospital Preference: _____

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1. Health and safety concerns at vocational site (explain).

2. Notify nurse when the following occurs: _____

   Symptoms:

_____ _____

Parent/Legal Guardian Signature *Date*

SCHOOL USE ONLY

Reviewed: _____ / _____ _____ / _____ _____ / _____

Initials *Date* *Initials* *Date* *Initials* *Date*