HS0062
Rev. 10/20

INDEPENDENCE ACADEMY STUDENT ACTION PLAN

Health Services Department
Lincoln Public Schools

Student: _____ ID#: _____ Date: _____

High School _____ School Year: _____ DOB: _____

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

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

Emergency Contact - if both guardians are unavailable:

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

Diabetes: ☐ No ☐ Yes (explain): _____

Seizure: ☐ No ☐ Yes (explain): _____

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

Asthma: ☐ No ☐ Yes (explain): _____

Special Diet: ☐ No ☐ Yes (explain): _____

If marked yes above, additional information and action plan will be needed for your student.

Medical Diagnosis:

Current Height: _____ Weight: _____

Current Medications: _____

Medications to be Given at School: _____
**Please note ibuprofen or acetaminophen can only be given with a written prescription.*

Physician Information:

Name: _____ Addresses: _____ Phone: _____

Name: _____ Addresses: _____ Phone: _____

Hospital Preference: _____

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

Parent/Legal Guardian Signature _____ *Date:* _____

PLEASE FILL OUT HEALTH HISTORY ON BACK WITH ANY PERTINENT UPDATED INFORMATION.

HS0001
Rev. 7/18

HEALTH HISTORY

Health Services Department
Lincoln Public Schools
Lincoln, Nebraska

Name _____ Birth Date _____ Sex _____

Parent or Guardian _____ Address _____ Phone _____

The following information is requested to assist the school staff in responding appropriately to your student's health needs. The information provided here may be shared with school personnel as needed to promote your child's safety and educational success at school.

A. Current Health Status

1. Does your child take medicine or supplements regularly? ☐No ☐Yes
   Please list: _____
2. Does your child have a health condition now under treatment? ☐No ☐Yes
   Please list: _____ Physician _____
3. Does your child currently have allergies?
   Please list: _____
4. Any concerns about your child's health? _____
5. Date of last medical exam _____ Dr. _____
6. Date of last dental exam _____ Dr. _____

B. Check conditions that pertain to your child or a doctor has observed and the date.

☐ Sleeping problem _____	☐ Hives _____	☐ Loss of consciousness _____
☐ Eating problem _____	☐ Chicken Pox _____	☐ Kidney problems/bedwetting _____
☐ Coordination problem _____	☐ Seasonal Allergies _____	☐ Heart problems _____
☐ Tires easily _____	☐ Asthma _____	☐ Diabetes _____
☐ Recurrent headaches _____	☐ Nosebleeds _____	☐ Migraines _____
☐ Weight problem _____	☐ Blow to head _____	☐ Convulsions or seizures _____
☐ Eczema _____	☐ Broken bones _____	☐ Behavior/emotional concerns _____

C. Illness and Accidents

Please explain each "yes" answer. Use other side as needed.

1. Has there been more than one ear infection each year? ☐No ☐Yes _____
2. Have there been any hearing problems? ☐No ☐Yes _____
3. Has there been a vision problem? ☐No ☐Yes
   If yes, when last fitted for glasses? _____
4. Has your child been hospitalized or had surgery? ☐No ☐Yes
   If yes, please specify? _____
5. Special Dietary/Nutritional Needs ☐No ☐Yes Please list _____
   If "Yes": Form NS0002 will need to be completed.

D. Previous History

Comments

Please explain any "yes" answers. Use other side as needed.

1. Were there any significant health concerns during pregnancy? ☐No ☐Yes _____
2. Was this pregnancy less than nine months? ☐No ☐Yes _____
3. Were there medical problems at birth? ☐No ☐Yes _____
4. Birth weight _____ .
5. At what age did your child walk alone? _____
6. At what age did your child say words with meaning? _____
7. Has your child been enrolled in any Lincoln Public Schools Early Childhood programs?
   ☐No ☐Yes Date _____ School Attended _____

E. Family History

1. List who lives in the home _____
2. List any family health problems _____

_____ _____ _____
Completed by Relationship to child Date

Return to School Health Office. Thank you.