HS0062 Rev. 10/20

## INDEPENDENCE ACADEMY STUDENT ACTION PLAN

## Health Services Department Lincoln Public Schools

Student:		ID	#:	Date:	
High School:		Sc	hool Year:	DOB:	
Guardian:		Phone (h):	(w):	(c):	
Guardian:		Phone (h):	(w):	(c):	
Emergency Contact - if b	ooth guard	lians 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, add	ditional inf	ormation and action plan will be	e needed for your student.		
Medical Diagnosis:					
Current Height:		Weight:			
Current Medications: _					
Medications to be Give *Please note ibuprofen o		ool: nophen can only be given with a	written prescription.		
Physician Information:					
Name:		Addresses:		Phone:	
Name:		Addresses:		Phone:	
Hospital Preference:					
Health and safety conce	rns at voc	ational site (explain).			
Parent/Legal Guardian S	ignature _			Date:	

HS0001 Rev. 7/18

## **HEALTH HISTORY**

## Health Services Department Lincoln Public Schools • Lincoln, Nebraska

Address Phone he following information is requested to assist the school staff in responding appropriately to your student's health beads. The information provided here may be shared with school personnel as needed to promote your child's safety and educational success at school.  Current Health Status  1. Does your child take medicine or supplements regularly?   No   Yes Please list:   Physician   Physician   Yes Please list:   Physician   Yes Please list:   Physician   Physician   Yes Please list:   Physician   Physici	Nan	ne _			Birth Date	Sex					
aeds. The information provided here may be shared with school personnel as needed to promote your child's safety and educational success at school.  Current Health Status  1. Does your child take medicine or supplements regularly?	are	ent	or Guardian Addres	S		Phone					
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: 3. Does your child currently have allergies?  Physician  3. Does your child currently have allergies?  Physician  4. Any concerns about your child's health?  5. Date of last medical exam	nee	ds.	The information provided here may be shared with school p								
Please list:  2. Does your child have a health condition now under treatment? No 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 medical exam Dr. 6. Date of last dental exam Dr. 6. Check conditions that pertain to your child or a doctor has observed and the date. Sleeping problem Hives Loss of consciousness Kidney problems/bedwetting Coordination problem Seasonal Allergies Heart problems Priese assily Asthma Diabetes Recurrent headaches Nosebleeds Migraines Weight problem Blow to head Convulsions or seizures Eczema Broken bones Behavior/emotional concerns 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 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 Frese: Form NS0002 will need to be completed. Previous History 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 walk alone? 7. Has your child been enrolled in any Lincoln Public Schools Early Childhood programs? 7. Has your child been enrolled in any Lincoln Public Schools Early Childhood programs? 8. List any family health problems 9. List any family health problems	٨.	Cu	rrent Health Status								
Please list: Physician  Does your child currently have allergies? Please list: Phase list:  4. Any concerns about your child's health?  5. Date of last medical exam Dr.  Check conditions that pertain to your child or a doctor has observed and the date.  Sleeping problem Dr.  Check conditions that pertain to your child or a doctor has observed and the date.  Sleeping problem Dr.  Check conditions that pertain to your child or a doctor has observed and the date.  Sleeping problem Dr.  Chicken Pox Nationary Chicken Pox Nationary Dr.  Chicken Pox Nationary Dr.  Chicken Pox Nationary Dr.  Chicken Pox Nationary Dr.  Check conditions that pertain to your child or a doctor has observed and the date.  Sleeping problem Dr.  Check conditions that pertain to your child or a doctor has observed and the date.  Check conditions that pertain to your child or a doctor has observed and the date.  Check conditions Dr.  Heat problems Dr.  Check conditions that pertain to your child or a doctor has observed and the date.  Chicken Pox Nationary Dr.  Check conditions that pertain to your child or a doctor has observed and the date.  Chicken Pox Nationary Dr.  Check conditions that pertain to your child or a doctor has observed and the date.  Chicken Pox Nationary Dr.  Check conditions that pertain to your child or a doctor has observed and the date.  Comments or potential pertain the pertain to your child search pertain the date.  List who lives in the home  List who lives in the home  List any family health problems		1.			☐ Yes						
Please list:  4. Any concerns about your child's health?  5. Date of last medical exam		2.									
5. Date of last medical exam		3.									
6. Date of last dental exam		4.	Any concerns about your child's health?								
Check conditions that pertain to your child or a doctor has observed and the date.    Sleeping problem		5.	Date of last medical exam Di	r							
Sleeping problem		6.	Date of last dental exam Di	r							
Sleeping problem	3.	Ch	eck conditions that pertain to your child or a doctor has	observed ar	nd the date.						
Illness and Accidents Please explain each "yes" answer. Use other side as needed.  1. Has there been more than one ear infection each year?			Eating problem		<ul><li>☐ Kidney prol</li><li>☐ Heart probl</li><li>☐ Diabetes _</li><li>☐ Migraines _</li><li>☐ Convulsion</li></ul>	blems/bedwetting ems s or seizures					
Please explain each "yes" answer. Use other side as needed.  1. Has there been more than one ear infection each year?					<b>D</b> enavior/e	motional concerns_					
If "Yes": Form NS0002 will need to be completed.  Previous History Please explain any "yes" answers. Use other side as needed.  Were there any significant health concerns during pregnancy? No Yes  Was this pregnancy less than nine months? No Yes  Were there medical problems at birth? No Yes  Birth weight  At what age did your child walk alone?  At what age did your child say words with meaning?  Has your child been enrolled in any Lincoln Public Schools Early Childhood programs?  No Yes Date School Attended  Family History  List who lives in the home  List any family health problems  List any family health problems		1. 2. 3. 4.	Has there been more than one ear infection each year?  Have there been any hearing problems?  No Yes  Has there been a vision problem?  No Yes  If yes, when last fitted for glasses?  Has your child been hospitalized or had surgery?  No If yes, please specify?	□ No □ `	-						
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<ul> <li>3. Were there medical problems at birth?  No Yes</li> <li>4. Birth weight</li></ul>	Ple	Ple	evious History ease explain any "yes" answers. Use other side as neede Were there any significant health concerns during pregnand	ed.							
<ul> <li>4. Birth weight</li></ul>		2.		Yes							
<ul> <li>5. At what age did your child walk alone?</li></ul>		3.	Were there medical problems at birth? ☐ No ☐ Yes								
<ul> <li>6. At what age did your child say words with meaning?</li></ul>		4.	Birth weight								
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List who lives in the home      List any family health problems		Far	mily History								
Completed by Relationship to child Date		2.	List any family health problems								
			Completed by Pal	ationship to a	hild						