HS0058
Rev. 1/09

# COMMUNITY ACTION PLAN
## Health Services Department
## Lincoln Public Schools

Student: _____ ID#: _____ Date: _____

School Address: _____ Grade: _____ DOB: _____

Parent: _____ Home Phone: _____ Work Phone: _____

Parent: _____ Home Phone: _____ Work Phone: _____

Emergency Contact - if both parents are unavailable:

Name: _____ Home Phone: _____ Work Phone: _____

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

Allergies: ☐ No ☐ Yes (explain):

_____

Diagnosis / Handicapping Condition

Physicians' Names and Addresses: 1. _____

2. _____

Hospital Preference: _____

Current Medications:

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

2. Notify nurse when the following occurs: _____

   Symptoms:

3. In case of emergency, call 911 if the following occurs:

   a. _____

   b. _____

   c. _____

   d. _____

**Remain Calm.** Offer reassurance to student.