

COMMUNITY ACTION PLAN
Health Services Department
Lincoln Public Schools

Student: _____ ID#: _____ Date: _____

School Address: _____ Grade: _____ DOB: _____

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

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

Emergency Contact - if both parents are unavailable:

Name: _____ 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: _____

Physician Information:

Name: _____ Addresses: _____ Phone: _____

Name: _____ Addresses: _____ Phone: _____

Hospital Preference: _____

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

2. Notify nurse when the following occurs: _____

Symptoms: _____

Parent/Legal Guardian Signature

Date