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

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

Comments

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.

HEALTH HISTORY: CULTURAL ASSESSMENT TOOL

Health Services Department
Lincoln Public Schools

Name _____ Birth Date _____

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 an educational success at school.

A. Language

1. What language is spoken at home? _____
2. Do you require an interpreter for verbal communications: ❑ No ❑ Yes
3. Do you require written communication in your home language? ❑ No ❑ Yes

B. Cultural Identification

1. Country of origin: _____
2. Describe your cultural identity (i.e. nationality, ethnicity, religion)

_____

C. Health Practices

1. How do you access healthcare (i.e. primary caregiver, emergency room, urgent care, other)?

_____

2. When do you seek medical care (i.e. wellness exams, emergency, ill visits, or never)?

_____

3. Any healthcare rituals that your family practices you would like the school to be aware of (i.e. coining, skin lightening, betel nut, shaving hair, hair oils)? _____
4. Will any of the above rituals impact health practices at school? ❑ No ❑ Yes

   If yes, explain: _____

D. Mental Health—Mental illness refers to a wide range of mental health conditions that affect your mood, thinking and behavior. Examples of mental illness: depression, anxiety, post-traumatic stress, ADHD, eating disorders, phobias, or other behavioral/emotional concerns.

1. Do you have any concerns about your chid's mental health? _____
2. Describe any family history of mental illness that may be impacting your student:

_____

3. Has your student experienced any traumatic events? ❑ No ❑ Yes

   If yes, explain: _____

E. Dietary Practices

1. Any specific dietary needs or restrictions? ❑ No ❑ Yes _____ (refer to NS0002)
2. Any cultural practices that may affect your student's diet? _____

F. Social Determinants

1. Do you feel that all of your family's basic needs are being met? ❑ No ❑ Yes
2. Any barriers that might hinder your child's success at school?
   ❑ Housing ❑ Food Assistance ❑ Transportation ❑ Financial Stressors ❑ Childcare
   ❑ No access to health insurance ❑ No primary care provider ❑ Other _____

Please contact the school nurse at your student's school for additional resources or answers to questions.