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.
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.