

HEALTH REPORT FOR SPECIAL EDUCATION EVALUATION PROCESS

Health Services Department • Lincoln Public Schools

Date Due: _____

Student's Name: _____ Student ID#: _____ Birth Date: _____

School: _____ Date: _____

Name of Person Interviewed: _____

Completed with Initial Evaluation

PRENATAL/EARLY DEVELOPMENT

1. Length of Pregnancy: _____ Birth Weight: _____

2. Complications Before/During/After Delivery: _____

3. Prenatal Exposure to Drugs/Alcohol: _____

4. Developmental hx., Approximate Age When: Sat up alone: _____ Walked: _____ Talked: _____

5. Environmental Conditions (*chemical/lead exposure, smoke, water quality*): _____

6. Screened or Served by LPS ECSE or Headstart: Yes No When: _____

7. Newborn Hearing Screening: Passed Failed Unsure

Complete with Initial Evaluation or Update Since Last Special Education Evaluation

CURRENT HEALTH STATUS

1. Physical Examination – (within 1 year) Date: _____ Physician: _____

Findings – Normal: _____ Other: _____

2. Vision Screen or Exam (within one year) – Date: _____ Results: _____

3. Near Vision Screen or Exam – Date: _____ Results: _____ Pass Fail

4. Hearing Screen (within one year) – Date: _____ Results: _____

5. Dental information that may impact education or speech: _____

6. Medications (*include OTC/vitamins/herbal remedies*):

Name of Med	Dosage	Time of Dose	Taken at School	
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

7. Significant changes in health conditions: _____

8. Current student plans related to health:

- No health plans
 Action plan
 Classroom plan
 Treatment plan (*Skilled nursing*)
 - Catheterization, trach/vent/suction, central line, enteral feeding/management, insulin injections, injectible medication (ex/Solu-cortef) Individual health plan (*IHP*)

9. Proposed nursing minutes _____ per _____ (week, month, quarter, semester, year)

Complete with Initial Evaluation or Update Since Last Special Education Evaluation
MEDICAL HISTORY

A. Serious illness/Physical, Mental or Behavioral Health Conditions:

B. Hospitalizations/Surgeries:

C. Serious Injuries/Accidents (*i.e. concussion, stitches, fx., poisonings, head injuries*):

D. Allergies/Reactions: Yes No

E. Family Medical History for Parent/Guardian: From your best knowledge (*i.e. ADHD, behavior disorders, alcohol/drug abuse, asthma, diabetes, depression, learning disability, mental illness, seizure disorder, etc.*):

Additional Comments/Remarks:

Nurse Signature: _____ Date: _____