HS0032
Rev. 11/24

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: _____

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
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

7. Significant changes in health conditions:

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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/Chronic Diseases:

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: _____