HS0032
Rev. 5/17

Lincoln Public Schools

Department of Student Services • 5905 O Street • Lincoln NE 68510 • (402) 436-1688 • (Fax) 436-1686

HEALTH REPORT FOR STUDENT ASSISTANCE PROCESS

Health Services Department
Lincoln Public Schools

Please use in conjunction with Tier 2 Evaluation Process

Requested by: _____ **Parent Permission:** ❑ **Yes** ❑ **No**

Reason for Eval/Reevaluation: _____ **Date Due:** _____

Student's Name: _____ Student ID#: _____

Birth Date: _____ School: _____ Date: _____

Name of Person Interviewed: _____

(*Completed with Initial Evaluation*)

I. PRENATAL/EARLY DEVELOPMENT

A. Length of Pregnancy: _____ Birth Weight: _____

B. Complications Before/During/After Delivery:

C. Prenatal Exposure to Drugs/Alcohol: _____

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

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

_____

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

(*Current or Update Since Last Special Education Evaluation)*

II. 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

(over)

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.)*:

F. Significant Family Changes in Last 12 Months for Parent/Guardian: Answer the best you can *(i.e. marriage/remarriage, divorce, separation, parent/child separation, death, financial difficulties, move, etc.)*:

G. Who Lives in the Household: _____

H. Strengths: _____

III. CURRENT HEALTH STATUS

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

Findings – Normal: Other:

B. Snellen Vision Screen (within one year) – Date: _____ Results: _____

C. Near Vision Exam – Date: _____ Results: ❑ Pass ❑ Fail _____

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

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

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

Name of Med	Dosage	Time of Dose	Taken at School
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

G. Significant changes in health conditions:

Additional Comments/Remarks:

Nurse Signature: _____ Date: _____

Completed form returned to Student Assistance Team member requesting information