

INDEPENDENCE ACADEMY STUDENT ACTION PLAN

Health Services Department Lincoln Public Schools

Student: _____ ID#: _____ Date: _____

High School: _____ School Year: _____ DOB: _____

Guardian: _____ Phone (h): _____ (w): _____ (c): _____

Guardian: _____ Phone (h): _____ (w): _____ (c): _____

Emergency Contact - if both guardians are unavailable:

Name: _____ Phone (h): _____ (w): _____ (c): _____

Diabetes: ☐ No ☐ Yes (explain): _____

Seizure: ☐ No ☐ Yes (explain): _____

Allergies/Anaphalaxis: ☐ No ☐ Yes (explain): _____

Asthma: ☐ No ☐ Yes (explain): _____

Special Diet: ☐ No ☐ Yes (explain): _____

If marked yes above, additional information and action plan will be needed for your student.

Medical Diagnosis: _____

Current Height: _____ Weight: _____

Current Medications: _____

Medications to be Given at School: _____

**Please note ibuprofen or acetaminophen can only be given with a written prescription.*

Physician Information:

Name: _____ Addresses: _____ Phone: _____

Name: _____ Addresses: _____ Phone: _____

Hospital Preference: _____

Health and safety concerns at vocational site (explain).

Parent/Legal Guardian Signature _____ Date: _____

PLEASE FILL OUT HEALTH HISTORY ON BACK WITH ANY PERTINENT UPDATED INFORMATION.

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.

- | | | |
|---|---|--|
| <input type="checkbox"/> Sleeping problem _____ | <input type="checkbox"/> Hives _____ | <input type="checkbox"/> Loss of consciousness _____ |
| <input type="checkbox"/> Eating problem _____ | <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Kidney problems/bedwetting _____ |
| <input type="checkbox"/> Coordination problem _____ | <input type="checkbox"/> Seasonal Allergies _____ | <input type="checkbox"/> Heart problems _____ |
| <input type="checkbox"/> Tires easily _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Recurrent headaches _____ | <input type="checkbox"/> Nosebleeds _____ | <input type="checkbox"/> Migraines _____ |
| <input type="checkbox"/> Weight problem _____ | <input type="checkbox"/> Blow to head _____ | <input type="checkbox"/> Convulsions or seizures _____ |
| <input type="checkbox"/> Eczema _____ | <input type="checkbox"/> Broken bones _____ | <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 2. Was this pregnancy less than nine months? <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 3. Were there medical problems at birth? <input type="checkbox"/> No <input type="checkbox"/> 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?
<input type="checkbox"/> No <input type="checkbox"/> 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 Independence Academy Teacher. Thank you.