

**VOICE 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): \_\_\_\_\_

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

Medical Diagnosis: \_\_\_\_\_

Current Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Current Medications:**

**Physician Information:**

Name: \_\_\_\_\_ Addresses: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Addresses: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

---

1. 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.**