

REQUEST FOR CURRENT HEALTH INFORMATION

Health Services Department
Lincoln Public Schools • Lincoln, Nebraska

Please use in conjunction with *The MDT Process*

Student Name: _____ Student ID#: _____

Grade: _____ Date of Birth: _____ Date: _____

Screen results as recorded on Student Health Record (only use data less than one year old):

Vision: _____ Date: _____ Results: _____

Near Vision (if available): _____ Date: _____ Results: _____

Hearing: _____ Date: _____ Results: _____

Dental information that may impact education or speech: _____

Medications: _____

History of concussion or head injury: _____

Additional information: _____

Health Technician: _____ Date: _____

School Nurse: _____ Date: _____

Return to: _____