Kindergarten Philosophy
For many children, attending kindergarten will be their first formal schooling experience. It is our goal to ensure that every child has a positive start and that each student receives challenging, yet achievable, instruction throughout the year.

Large group, small group, and individualized instruction ensure that your child’s learning needs are met, and a variety of hands-on materials and sensory experiences allow for active involvement. All students receive classroom instruction based on a district-wide curriculum, including reading, writing, speaking, listening, math, health, social studies, science, and character education.

Helpful Ideas for Parents/Guardians for Kindergarten Readiness
LPS encourages self-respect and self-confidence in students. Teachers try to help students continue to inquire, learn and respond successfully to change. Upon starting school, many children already have developed these characteristics. A child’s first impression of school and the people they meet will have an impact on the child’s feelings about school and themselves. It’s important that all children feel good about their early school experiences.

When a child starts school, it may be the first time away from parents/guardians and the first experience in organized education. There are several things you can do to promote a child’s health, safety and well-being, and to make the first days of school happy ones.

Here are some ideas you can use to promote a successful school experience:

A. Give your child a sense of security and a feeling of belonging.
   1. Show affection through closeness and gentleness.
   2. Give approval more often than correction.
   3. Include your child in family activities.
   4. Avoid comparing your child with others, because everyone learns at a different time and rate.

B. Help your child look forward to pleasant experiences at school.
   1. Talk about school being a place where a child participates in many exciting things.
   2. Reinforce what your child already knows and can do, rather than worry your child about what he/she will have to know and do at school.
   3. Talk about the friendships that will develop at school.
   4. Support and encourage your child’s effort when he/she tries new things.
   5. If you are feeling anxious about kindergarten, do not express those feelings to your child.

C. Make certain your child’s health and safety comes first.
   1. Schedule a physical exam before school begins.
   2. Provide for necessary physical corrections (such as glasses) before school starts.
   3. Make sure recommended immunizations are given.
   4. Establish good health habits in relation to meals, bathroom and rest (e.g., washing hands.)
   5. Keep your child home if he/she has a cold or is not feeling well.
   6. Send a note to the teacher when special attention is needed.
7. Teach your child her/his name, parents'/guardian's names, address, and telephone number.
8. Teach your child how to walk safely to and from school, including where to cross streets, how to obey traffic signals, staying on the sidewalk and crossing only at corners.
9. Discuss with the teacher any physical, emotional, social or mental conditions that may affect your child's progress in school.
10. Contact the school nurse if your child has special health care needs.

D. Dress your child in clothing that allows for active participation.
   1. Choose easy care clothing.
   2. Label clothing, such as coats, jackets, sweaters, sweatshirts, boots, gloves, backpacks and lunch boxes with your child's name so they do not get lost or mixed up with another child's belongings.
   3. Provide suitable and comfortable clothing that your child can easily manage alone.

E. Help your child develop independence.
   1. Give your child special tasks at home that are within her/his ability.
   2. Encourage your child to pick up personal belongings.
   3. Make sure your child is able to use the bathroom independently.
   4. Listen attentively when your child is talking.
   5. Encourage adult speech, rather than baby talk.
   6. Practice zipping, buttoning, snapping and tying clothes and shoes with your child.

F. Show your child that you are interested in school and that school is important.
   1. Welcome your child's voluntary talk about school, but don't insist that a full report be made on all experiences. Ask open-ended questions about your child's day, such as, "What was the best thing about school today?"
   2. Attend activities at school, such as parent-teacher conferences, open houses, curriculum nights and school programs.
   3. Take part in school activities, such as class trips, parties, parent classes and groups.
   4. Take an interest in papers, projects and artwork created at school.

G. Help your child be successful in school.
   1. See that attendance is regular.
   2. See that your child arrives at school on time.
   3. Select a place in your home for your child to keep items needed for school, such as a backpack and library books.
   4. Expect the same type of growth that the school expects by not urging skills that are beyond the level of your child.
   5. Select appropriate television programs for your child, and limit the time your child watches television and plays video games.
   6. Read to your child and tell stories. Encourage your child to retell stories with your help.
   7. Give your child out-of-school experiences, such as museums, parks, zoos, fairs, grocery shopping and visits to the library.
   8. Play games with your child.
   9. Maintain contact with your child's teacher. Call, email, or send a note when you have questions. Inform the teacher of days when your child will be absent.
10. Inform the teacher if there is a change in whom your child will be going home with or how your child will get home.

H. Help your child grow literacy skills at home.
   1. Talk to your child. Ask your child "how" and "what" questions. These require more than a yes or no answer.
   2. Read to your child. This exposes them to new words, language and concepts.
   3. Talk about letters and words. Make it a game to look for letters. Count the words on signs or packages.
   4. Help your child learn to write his/her name in lowercase letters with the first letter capitalized.

**If you have questions regarding your child's readiness for kindergarten, contact your child's school.**
## Elementary School Start and End Times

School start and end times may be subject to change. Please contact individual schools for more information.

<table>
<thead>
<tr>
<th>Elementary (K-S)</th>
<th>Start</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams</td>
<td>8:15 a.m.</td>
<td>2:53 p.m.</td>
</tr>
<tr>
<td>Arnold</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Beattie</td>
<td>8:15 a.m.</td>
<td>2:53 p.m.</td>
</tr>
<tr>
<td>Belmont</td>
<td>8:15 a.m.</td>
<td>2:53 p.m.</td>
</tr>
<tr>
<td>Brownell</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Calvert</td>
<td>8:15 a.m.</td>
<td>2:53 p.m.</td>
</tr>
<tr>
<td>Campbell</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Cavett</td>
<td>8:15 a.m.</td>
<td>2:53 p.m.</td>
</tr>
<tr>
<td>Clinton</td>
<td>8:15 a.m.</td>
<td>2:53 p.m.</td>
</tr>
<tr>
<td>Eastridge</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Elliott</td>
<td>8:15 a.m.</td>
<td>2:53 p.m.</td>
</tr>
<tr>
<td>Everett</td>
<td>8:15 a.m.</td>
<td>2:53 p.m.</td>
</tr>
<tr>
<td>Fredstrom</td>
<td>8:15 a.m.</td>
<td>2:53 p.m.</td>
</tr>
<tr>
<td>Hartley</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Hill</td>
<td>8:15 a.m.</td>
<td>2:53 p.m.</td>
</tr>
<tr>
<td>Holmes</td>
<td>8:15 a.m.</td>
<td>2:53 p.m.</td>
</tr>
<tr>
<td>Humann</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Huntington</td>
<td>8:15 a.m.</td>
<td>2:53 p.m.</td>
</tr>
<tr>
<td>Kahoa</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Kloefkorn</td>
<td>8:15 a.m.</td>
<td>2:53 p.m.</td>
</tr>
<tr>
<td>Kooser</td>
<td>8:15 a.m.</td>
<td>2:53 p.m.</td>
</tr>
<tr>
<td>Lakeview</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Maxey</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>McPhee</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Meadow Lane</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Morley</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Norwood Park</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Pershing</td>
<td>8:15 a.m.</td>
<td>2:53 p.m.</td>
</tr>
<tr>
<td>Prescott</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Pyrtle</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Randolph</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Riley</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Roper</td>
<td>8:15 a.m.</td>
<td>2:53 p.m.</td>
</tr>
<tr>
<td>Rousseau</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Saratoga</td>
<td>8:15 a.m.</td>
<td>2:53 p.m.</td>
</tr>
<tr>
<td>Sheridan</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>West Lincoln</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Wysong</td>
<td>9:00 a.m.</td>
<td>3:38 p.m.</td>
</tr>
<tr>
<td>Zeman</td>
<td>8:15 a.m.</td>
<td>2:53 p.m.</td>
</tr>
<tr>
<td>Don D. Sherrill Ed. Ctr. (K-S)</td>
<td>9:10 a.m.</td>
<td>3:30 p.m.</td>
</tr>
</tbody>
</table>
If you did not upload the following forms when you registered online, you will need to bring them to your child’s school BEFORE the first day of school:

- Certified Birth Certificate
- Current Immunization Record

The school must have the following BEFORE the first day of school:

- Proof of Dental Examination Card
- Physical Examination Requirements Form
- Report of Vision Evaluation Form
- Medical Statement for Students Requiring Special Meals Form
DO bring your current immunization record to Kindergarten Registration
You DO NOT need to bring the form below, it is for informational purposes only

IMMUNIZATION REQUIREMENTS
Health Services Department
Lincoln Public Schools
Lincoln, Nebraska

Requirements for Immunizations:

Nebraska Law requires that students shall be protected against poliomyelitis, Diptheria, Pertussis, Tetanus (DPT), Measles, Mumps, Rubella (MMR), Hepatitis B, and Varicella (chicken pox). Any student who does not comply with immunization requirements shall not be permitted to continue in school until he or she shall so comply. A student may be provisionally enrolled if he or she has begun the immunizations required under Nebraska Law. For more information, please contact the school nurse in your student’s building of enrollment or call 436-1655.

All students enrolling at the beginner grade (kindergarten or first grade) through twelfth grade, including out of state transfers to any grade, are required to show record of: Three doses of DtaP, DTP, DT, or Td vaccine with at least one dose given no earlier than four (4) days before the fourth birthday; three doses of Polio vaccine; 2 doses of MMR vaccine with the first dose given no earlier than four (4) days before the first birthday and the two doses separated by at least 28 days; two doses of Varicella, with the first dose given no earlier than 4 days before the first birthday and each dose given at least 28 days apart OR provide a signed parent/guardian statement of past history of chicken pox disease, including year of illness; three doses of pediatric Hepatitis B vaccine, or if the alternate Hepatitis B schedule is used, two doses of adult Hepatitis B vaccine specified for adolescents 11-15 years of age. The alternate two-dose schedule must be administered with at least 112 days between #1 and #2, and must be completed before the 16th birthday.

Additional Note: One Tdap (Tetanus, diphtheria,acellular pertussis) is required for entry to 7th grade. The vaccination can be given after the seventh birthday depending on the brand of vaccine received and prior to entry to 7th grade.

Doses must meet minimum interval guidelines to be considered valid.

Hepatitis B Minimum Intervals:

a) 28 days minimum between dose #1 and #2
b) 112 days minimum between dose #1 and #3
c) 56 days minimum between dose #2 and #3
d) The minimum age for dose #3 is 164 days of age

Please submit a copy of your student’s immunization record to the Health Office.

For waiver information please call 436-1655 or contact the school nurse at the school of enrollment.
REPORT OF DENTAL EXAMINATION
Health Services Department
Lincoln Public Schools

This is to certify that I have thoroughly examined the teeth of

________________________________________
(Full Name)

☐ All necessary dental work has been completed.
☐ No dental work is necessary at this time.
☐ Treatment is scheduled.

Further recommendations _______________________________________________________

_________________________ ____________________________
Date Signature of Dentist

Please return this form to the school after your child’s visit to the dentist. Forms returned with
signature of dentist within the current year prior to the school dental inspection exempts the
child from the school dental inspection.

This form was prepared by the Lincoln Public Schools in cooperation with the Lincoln District Dental Society.
PHYSICAL EXAMINATION REQUIREMENTS
Health Services Department
Lincoln Public Schools

"The Board of Education shall require evidence of a physical examination by a physician, physician assistant, or an advanced practice registered nurse within six months prior to the entrance of a child into the beginner grade and the seventh grade, or in the case of a transfer from out-of-state to any other grade of the local school; provided no such examination shall be required of any child whose parent or guardian shall object thereto in writing. A complete visual evaluation is required at the entry grade (kindergarten, or grade of transfer from out of state). A vision professional may also complete the required visual evaluation. Waiver forms are available in each school health office. School Law 79-214 (g). Physical examinations are recommended at the third and tenth grade in addition to the required examinations.

Each student participating in interscholastic athletics is required to have a complete physical examination (Nebraska School Activities Association requirement) to be given after May 1 of each year. This certifies that the athlete is qualified for the entire school year, May 1 through the following closing day of school, or the current school year.

For participation in interscholastic athletics, please complete other side.

Name __________________________________________________________
Address ________________________________________________________ Zip ____________ DOB _________ Sex  M  F
Medical Provider _______________________________________________________

Date _______________

PHYSICAL FINDINGS

Height _______________ Weight _______________
Blood Pressure _______________ Pulse _______________

Additional Lab Results

Immunizations given during today’s visit:
☐ DTP  ☐ Tdap  ☐Td  ☐ polio  ☐ MMR  ☐ Hib
☐ Hep B  ☐ Hep A  ☐ HPV  ☐ Meningococcal
☐ Varicella  ☐ other (list)  ____________________

(Please attach copy of immunization record on file.)

Audiometric Screening Report, if given

<table>
<thead>
<tr>
<th>500</th>
<th>1000</th>
<th>2000</th>
<th>4000</th>
</tr>
</thead>
<tbody>
<tr>
<td>RE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LE</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PASS  FAIL  RECOMMEND FURTHER EVALUATION (see comments below)

Operation | Right | Left | with | without glasses
---|-------|------|------|-------------------
Amblyopia | ☐ | ☐ | ☐ | ☐
Strabismus | ☐ | ☐ | ☐ | ☐
Internal Eye Health | ☐ | ☐ | ☐ | ☐
External Eye Health | ☐ | ☐ | ☐ | ☐
Visual Acuity | ☐ | ☐ | ☐ | ☐

20 feet: Right 20/_____ Left 20/_____ with | without glasses
16 inches: Right 20/_____ Left 20/_____ with | without glasses

MEDICAL Normal Abnormal Findings

Appearance
Eyes/ears/nose/throat
Lymph Nodes
Heart (murmur if present)
Pulses (inc. Femoral)
Lungs
Abdomen
Skin

MUSCULOSKELETAL

Neck
Spine
Shoulder/arm
Wrist/hand
Elbow/forearm
Hip/thigh
Knee
Leg/ankle
Foot

Evidence of Hernia ☐ No ☐ Yes
Stigmata of Marfan’s Syndrome ☐ No ☐ Yes

Significant findings/Chronic Health Problems (please review health history) __________________________________________________________

Required medication on a daily or episodic routine __________________________________________________________

Please check classification
☐ Regular: Student may participate in the regular program of physical education, recreation, intramurals, athletics or related activities without undue risk or injury.
☐ Adapted: Student has a condition which might risk sustaining injury from participation in the regular program or needs a special adapted program as indicated by the consulting physician. Reexamine each year.
☐ Exempt: Student has a severe handicap which might risk sustaining injury from participation in the regular program or needs a special adapted program. These students should be re-examined for possible reclassification at the end of the exemption period.

Please check certification
☐ Certified: Student has passed the physical examination successfully and is physically able to participate in interscholastic athletics.
Activities student should not participate in __________________________________________________________

Recommendations: __________________________________________________________

Your signature below indicates completion of physical exam and review of health history.

Date _______________ Signed __________________

Examing Provider (Signature Required)

Clinic/Practice Name (please print) __________________________________________________________

Lincoln Public Schools

Return to School Health Office

2021 Elementary Registration Packet
# PHYSICAL EXAMINATION REQUIREMENTS
## (Preparticipation Medical History)
### Lincoln Public Schools

The Lincoln Public Schools’ Medical Advisory Committee recommends that every student participating in interscholastic athletics complete a medical questionnaire to reduce the risk of serious injury in young athletes. In addition to physical examination by a qualified health professional, completion of the following questions will aid the identification of any health concerns related to athletic participation.

**Parent or Guardian:** Please complete and sign below if your child is interested in interscholastic sports participation.

Name __________________________________________________________

Parent or Guardian: ____________________________________________

Address ________________________________________________________ Zip ____________  DOB _________  Sex  □ M □ F

Sport ____________________________________________________________

---

**LEAVE BLANK IF ANSWER IS UNKNOWN. EXPLAIN "YES" ANSWERS BELOW.**

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Has there been a medical illness or injury since the last checkup or sports physical?</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Has the student ever been hospitalized overnight?</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Is the student currently taking any prescription or nonprescription (over-the-counter) medications?</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Does the student have any allergies (for example, to pollen, medicine, food or stinging insects)?</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Has the student ever passed out during or after exercise?</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Does the student get tired more quickly than friends do during exercise?</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Has the student ever had a rash or hives develop during or after exercise?</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Has the student ever become ill from exercising in the heat?</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Does the student cough, wheeze or have trouble breathing during or after activity?</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Does the student have any other problems with pain or swelling in muscles, tendons, bones or joints (Check which apply.)</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Has the student ever had surgery?</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Has the student ever had a stinger, burner or pinched nerve?</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Does the student want to weigh more or less than at present?</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Does the student complain of feeling stressed out?</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>When was the first menstrual period?</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>When was the most recent menstrual period?</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>How many periods have the female student had in the past year?</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>What was the longest time between periods in the past year?</td>
<td></td>
</tr>
</tbody>
</table>

**FEMALES ONLY**

<table>
<thead>
<tr>
<th>Question</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the student had any other problems with pain or swelling in muscles, tendons, bones or joints? (Check which apply.)</td>
<td></td>
</tr>
<tr>
<td>Has any family member or relative been diagnosed with cardiomyopathy (thick heart), long QT Syndrome or Marfan Syndrome?</td>
<td></td>
</tr>
<tr>
<td>Has the student had a severe viral infection (for example myocarditis or mononucleosis) within the past month?</td>
<td></td>
</tr>
<tr>
<td>Has a physician ever denied or restricted participation in sports for any heart problems?</td>
<td></td>
</tr>
<tr>
<td>Does the student have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?</td>
<td></td>
</tr>
<tr>
<td>Has the student ever had a head injury or concussion?</td>
<td></td>
</tr>
<tr>
<td>Has the student ever been knocked out, become unconscious or lost their memory?</td>
<td></td>
</tr>
<tr>
<td>Has the student ever had a seizure?</td>
<td></td>
</tr>
<tr>
<td>Does the student have frequent or severe headaches?</td>
<td></td>
</tr>
<tr>
<td>Does the student ever have numbness or tingling in arms, hands, legs or feet?</td>
<td></td>
</tr>
<tr>
<td>Has the student ever had a stinger, burner or pinched nerve?</td>
<td></td>
</tr>
</tbody>
</table>

---

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. The information provided here may be shared with other school personnel as needed to promote your child’s safety and educational success at school.

Signature of athlete ____________________________________________

Signature of parent/guardian ________________________________  Date ____________

---

Lincoln Public Schools 2021 Elementary Registration Packet
Nebraska State Statute requires students entering kindergarten (or first grade, if not enrolled in kindergarten) to provide evidence of vision evaluation within six months prior to entry. This requirement also applies to out-of-state transfers to any grade.

The evaluation may be performed by a physician, physician assistant, advanced practice registered nurse, or vision professional (optometrist or ophthalmologist).

Children are exempt from this requirement when the parent/guardian provides a written statement of objection. For more information about the vision requirement, including the availability of resources for low-income families, please contact the school nurse in your child’s school, or the district health services office at 436-1655.

Name: ___________________________  ID#: ___________________________

Examiner: ___________________________  Date: ___________________________

**ALL OF THE FOLLOWING MUST BE COMPLETED TO MEET NEBRASKA STATUTE REQUIREMENTS:**

<table>
<thead>
<tr>
<th></th>
<th>PASS</th>
<th>FAIL</th>
<th>RECOMMEND FURTHER EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amblyopia</td>
<td></td>
<td></td>
<td>(see comments below)</td>
</tr>
<tr>
<td>Strabismus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Eye Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>External Eye Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual Acuity</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20 feet
| Right 20/ _______ | Left 20/ _______ | with/without glasses |

16 inches
| Right 20/ _______ | Left 20/ _______ | with/without glasses |

**COMMENTS/RECOMMENDATIONS:**

________________________________________

________________________________________

Examiners Signature  Date

Lincoln Public Schools  2021 Elementary Registration Packet
Resources for Low-Income Families Who May Qualify for Free or Reduced-Cost Vision Evaluations

1. **Insurance coverages** - Many insurance companies cover the cost of an eye exam (Blue Cross/Blue Shield, United Health Care, Coventry, Vision Service Plan, Spectera, etc.). Check with the company as to details of vision care coverage.

2. **Employer-based options** - Parents with cafeteria plans, Medical Savings Accounts, Health Savings Accounts, or other flexible spending plans through employers can typically use these accounts to pay for vision exams.

3. **Medicaid and Kids Connection** - Office visits, eye exams and glasses are covered. Local social service offices have details as to eligibility.

4. **SIGHT FOR STUDENTS** - Provides free exam, discounted eyewear for eligible students from participating optometrists. Check website for details: www.sightforstudents.org. School nurses may also have vouchers.

5. **Lions Clubs of Nebraska** - Clubs located throughout the state provide vision care assistance for needy families. Usually involves referral by teacher, clergy or health professional. Contact local clubs for details.

6. **Community health centers and services** - Community health centers and community-based health services throughout the state can provide free eye exams for low income families that qualify, or coordinate the availability of reduced-cost services. Check with local social service agencies for options near you.

7. **Discount plans from health care providers** - Many optometrists and other health care providers offer family discounts, package pricing on children’s eyewear, and other in-office discounts. Check with local providers for options.

8. **Vision USA** - Low income families with working parent and no vision insurance may qualify for free exams from participating optometrists. Call 1-800-766-4466 or check the Nebraska Optometric Association website: http://nebraska.aoa.org/visionusa.sml for eligibility guidelines and information about scheduling appointments. There is also a Spanish version of the Vision USA application - nebraska.aoa.org/documents/VISIONUSAAppSpanish.doc.

9. **SEE TO LEARN®** - A free vision assessment for your three-year old is provided by a participating Eye Care Council eye care professional. SEE TO LEARN® is a preventative health program designed to ensure that kindergarten children entering school can see to learn. This program also educates parents and teachers about the warning signs of vision problems in all school-age children. For participating doctors, call 1-800-960-EYES or visit http://www.seetolearn.com/see-to-learn.html.

10. **InfantSEE®** - InfantSEE® is a public health program designed to ensure that eye and vision care becomes an integral part of infant wellness care to improve a child’s quality of life. Under this program, an American Optometric Association member optometrist will provide a comprehensive infant eye assessment within the first year of life as a no cost public health service. For participating doctors, call 888-396-EYES or go to www.infantsee.org.


Compiled by Nebraska Foundation for Children’s Vision (www.NEchildrensvision.org)
Dear Parent or Guardian,

SPECIAL DIETS FOR ALLERGIES AND MEDICAL CONDITIONS: If your student has a diagnosed food allergy, food intolerance, medical condition or disability which requires a special diet, LPS Nutrition Services will accommodate that dietary request upon receipt of a completed Medical Statement For Students With Special Nutritional Needs (page 2 of this form). Section 2 – Diet Order must be completed by your licensed health care professional. A note from a physician on a prescription pad or office letter head cannot be accepted because it does not contain all the required information or parent signature. Information required includes:

- The child’s medical condition, allergy or impairment that requires a dietary modification.
- The specific dietary restrictions, modifications or instructions to treat the identified medical condition.
- Approval to use almond or rice milk substitutes if student is unable to tolerate lactose-free or soy milk.
- Other instructions such as texture modifications or thickening of liquids to ensure the student meal can be safely consumed.

To ensure student safety, allow up to 5 school days from receipt of the Medical Statement for Nutrition Services to plan and obtain special foods needed for your child. During this time, please plan to send a lunch from home. If your student does not eat meals at school and will always bring lunch from home, it is still important for the school health office to be aware of all medical conditions including food allergies.

Please feel free to call or email Lynn Goering, Special Diet Dietitian at 402-436-1745 or lgoering@lps.org. The LPS website also contains a wealth of information about special diets, including Q&A’s, special menus and other information: The webpage can be found at lps.org, scroll down to the “Special Diet” link or type “special diets” in the search box.

PARENT REQUEST – PERSONAL DIETARY CHANGE: A parent may request any of the following three dietary changes by filling out SECTION 3 of the Medical Statement For Students With Special Nutritional Needs form. The signature of your health care provider is not needed for these 3 requests.

(1) A Meatless Entrée, No Pork or No Beef Entrée
(2) Lactose-Free Milk
(3) Soy Milk

*As a courtesy for our diverse student population, the daily menu includes at least two meatless choices every day. Some will contain cheese, milk and/or eggs, and one will be plant based.

USDA NON-DISCRIMINATION STATEMENT: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) Fax: (202) 690-7442; or

(3) Email: program.intake@usda.gov

This institution is an equal opportunity provider.
MEDICAL STATEMENT FOR STUDENTS WITH SPECIAL NUTRITIONAL NEEDS
Nutrition Services Department
Lincoln Public Schools

INSTRUCTIONS: Complete SECTION 1 – STUDENT INFORMATION. This form may be used for the following:

1. **Special Diet Needed Due to Allergy, Intolerance, Medical Condition or Disability** – Health Care Provider completes SECTION 2.
   SECTION 2 MUST be completed and signed by a State Licensed Health Care Professional (Physician (MD or DO), Physician’s Assistant (PA), Advance Practice Registered Nurse-Nurse Practitioner (APRN-NP), or Chiropractor (DC). A Licensed Medical Nutrition Therapist (LMNT) may also complete and sign when acting under the consultation of a licensed physician. This section cannot be completed by the parent/guardian.

2. **Parent Request For Dietary Change For Personal Reasons** – Parent completes and signs SECTION 3.
   The parent should complete both SECTION 1 and SECTION 3 (skip Section 2) to request the following three dietary change(s): A. Meatless/Vegetarian B. Lactose-Free Milk C. Soy Milk. The signature of a State Licensed Health Care Provider is not needed for these three requests. Use box D. to document a peanut, tree nut allergy.

QUESTIONS: Please call Lincoln Public Schools, Nutrition Services Dietitian at 402-436-1745.

RETURN COMPLETED FORM: To the school’s Health Office or via fax to Nutrition Services 402-436-1775.

To ensure student safety, please allow up to 5 school days from receipt of this form for Nutrition Services to plan menu changes and obtain the special foods needed for your student. During this time, please send a lunch from home.

### SECTION 1 – STUDENT INFORMATION

<table>
<thead>
<tr>
<th>Student Name (First):</th>
<th>(Last):</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Name (First):</td>
<td>(Last):</td>
<td>Student ID:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Email:</td>
<td>School:</td>
</tr>
<tr>
<td>Grade:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SECTION 2 – SPECIAL DIET FOR ALLERGY, INTOLERANCE, MEDICAL CONDITION OR DISABILITY

Section 2 MUST be completed and signed by a Licensed Provider (MD, DO, PA, APRN-NP, DC, LMNT). See instructions.

A. Student’s Diagnosis, Food Allergy, Intolerance or Medical Condition:

B. Dietary Restriction, Modification or Prescription OR Check all that apply:

   **DAIRY/MILK:**
   - [ ] Dairy Free Diet
   - [ ] Low Lactose Diet

   **MILK SUBSTITUTE:**
   - [ ] Soy Milk
   - [ ] Lactose-Free

   **APPROVED USE OF OTHER MILK SUBSTITUTES:**
   Check all that apply (not nutritionally equivalent to milk).
   - [ ] Rice Milk
   - [ ] Almond Milk

   **GLUTEN/WHEAT:**
   - [ ] Gluten Free Diet

   **TEXTURE MODIFICATIONS:**
   - [ ] Soft
   - [ ] Chopped
   - [ ] Puree
   - [ ] Other:

   **THICKENED LIQUIDS:**
   - [ ] Nectar
   - [ ] Honey
   - [ ] Pudding
   - [ ] Other:

C. Printed Name Licensed Health Care Provider:

D. Signature Health Care Provider:

<table>
<thead>
<tr>
<th>Phone:</th>
<th>Date:</th>
</tr>
</thead>
</table>

### SECTION 3 – PARENT REQUEST – PERSONAL DIETARY CHANGE

Check all that apply.

A. [ ] Meatless/Vegetarian. Or check only those that apply:
   - [ ] No Beef
   - [ ] No Pork
   - [ ] No Chicken
   - [ ] No Turkey

**PLEASE NOTE:** LPS offers at least 2 meatless options every day, one of which will be plant based. Due to cost and availability, we are unable to fulfill requests for organic food.

B. [ ] Lactose-Free Milk

C. [ ] Soy Milk

**PLEASE NOTE:** Health Care Provider approval is required for all other types of milk substitutes, which are not nutritionally equivalent to cow’s milk.

D. [ ] Peanut Allergy

E. [ ] Tree Nut Allergy

**Signature Parent/Guardian:**

<table>
<thead>
<tr>
<th>Date:</th>
</tr>
</thead>
</table>

I give permission for the school to follow the above diet and agree to allow the school to share information on a “need to know” basis with their employees in order to accommodate meals and food related activities. I agree to allow my child’s health care provider and school personnel to discuss information on this form.

**OFFICE USE**

<table>
<thead>
<tr>
<th>Date Received:</th>
</tr>
</thead>
</table>

- [ ] Emailed
- [ ] FAXED
- [ ] Copy

To: [ ] Health Office  [ ] LPSDO  [ ] Cafeteria

Initials: