LINCOLN SCHOOL
KATHMANDU, NEPAL

INDIVIDUAL HEALTH CARE PLAN

Name of Student: _____ Sex: M / F *(circle)*
Last *First* *Middle*

Date of Birth: ____/____/____ Grade: _____
mm / dd / yyyy

A. **The following section is to be completed by the HEALTH CARE PROVIDER** *(Please print)*

The above named student has been diagnosed with: _____

Actions at school to support the student: _____

Special considerations and safety precautions: (regarding school activities, PE, sports, etc.): _____

Medication(s) taken/given **DAILY AT HOME**:

Medication Name	Dose	Route	Time(s)	Significant Side Effects
1.				
2.				

Medication(s) to be taken/given **DAILY AT SCHOOL**:

Medication Name	Dose	Route	Time(s)	Significant Side Effects
1.				
Is the child authorized to medicate himself/herself? 7 Yes 7 No If Yes, I have instructed the student in the purpose and appropriate method or frequency of use; and student demonstrates necessary skill to use this medication and to use any device necessary to administer medication.				
2.				
Is the child authorized to medicate himself/herself? 7 Yes 7 No If Yes, I have instructed the student in the purpose and appropriate method or frequency of use; and student demonstrates necessary skill to use this medication and to use any device necessary to administer medication.				

Medication to be taken **AT SCHOOL WHEN NEEDED** or **FOR AN EMERGENCY**:

Medication Name	Dose	Route	Significant Side Effects

Indications for giving OR describe what is an emergency: _____

How soon can it be repeated? _____

Is the child authorized to medicate himself/herself? 7 Yes 7 No

If Yes, I have instructed the student in the purpose and appropriate method or frequency of use; and student demonstrates necessary skill to use this medication and to use any device necessary to administer medication.

Length of time this treatment is recommended: _____

Other information: _____

Physician signature:	Date:
Physician name:	

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Date of Birth:_____/_____/_____ Grade: _____
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B. **The following section is to be completed by the PARENT/GUARDIAN** *(Please print)*

Please check the box that applies:

- ☐ I request that the authorized person at school assist my child in taking the medicine(s) described on the front of this page.
- ☐ I request that my child be permitted to medicate himself/herself at school.

I also give my permission for the exchange of information between the school staff and the health care provider listed above. I understand that the medication is to be furnished by me in the original container, labeled with the name, strength and expiration date of the medication.

If the parent/guardian elects to authorize the student to medicate himself/herself at school, the parents/guardians shall hold harmless and indemnify the Lincoln School and the school's officers, employees and agents against all claims, judgments or liabilities arising out of the self-administration and carrying of medication by the above mentioned child.

Parent signature:_____Date:_____
Parent name: _____

INDIVIDUAL HEALTH CARE PLAN AUTHORIZATION

Parent signature:	Date:
Parent name:	

EMERGENCY CONTACT INFORMATION

Name of Parent/Guardian:			
1.	Home:	Work phone:	Mobile:
2.	Home:	Work phone:	Mobile:

Emergency Contacts:			
1.	Home:	Work phone:	Mobile:
2.	Home:	Work phone:	Mobile:

Name of local physician:	Work phone:	Mobile:
Location of local physician:	E-mail:	

Name of local hospital:	Phone:	
Location of local hospital:		

Lincoln School Nurse: Marsha Dupar	School: 427 0482, 427 0603	Home: 517 8404	Mobile: 98011 00932