EST. 1954
LINCOLN SCHOOL
KATHMANDU, NEPAL

# LINCOLN SCHOOL
# INDIVIDUAL HEALTH CARE PLAN

Name of Student: _____
*Last* *First* *Middle*

*Sex: M / F / Intersex (circle)*

Date of Birth: _____/_____/_____
*mm / dd / yyyy*

Grade: _____

## *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? ☐ Yes ☐ No<br>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? ☐ Yes ☐ No<br>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? ☐ Yes ☐ 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: | Mobile: |

# LINCOLN SCHOOL
# INDIVIDUAL HEALTH CARE PLAN

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

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

*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 Nurses:** Shanti Shrestha Neupane, and Poonam K.C. **School:** 015371436, Ext 129 healthoffice@lsnepal.com