



INDIVIDUAL HEALTH CARE PLAN

Name of Student: _____
Last First Middle

Sex: M / F (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

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.				
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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.

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: _____	

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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: 446 0404	Mobile: 985 111 0959
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