



Child's Name	Nickname	Date Of Birth
Parent Caregiver	Relationship	
Address		
Home Phone	Blocked? <input type="radio"/> Y <input type="radio"/> N	E-mail
Best Time to Reach	Mother Alternate Phone	
Father Alternate Phone		Relationship
Emergency Contact	Phone	Relationship
Emergency Contact	Phone	Relationship
Health Insurance/Plan	Identification #	

Diagnoses	Emergency Plan? <input type="radio"/> Yes <input type="radio"/> No	Complexity Level _____
Primary	Primary	
Secondary	Secondary	
Secondary	Secondary	
Allergies/Reaction _____		
Medications/Dose _____		

Primary Care Clinician	Phone	Fax	E-Mail
Specialist/Specialty	Clinic/Hospital	Phone	Other Fax, E-mail, Etc.
#1			
#2			
#3			
Nursing Service/Respite	Phone		

Specialized Emergency Information



Child's Name _____

Nickname _____

DOB _____

Common Presenting Problems/Findings with Specific Suggested Managements

See specialist letter(s) attached.

Problem #1 _____

Presenting Signs & Symptoms _____

Suggested Diagnostic Studies _____

Treatment Considerations _____

Problem #2 _____

Presenting Signs & Symptoms _____

Suggested Diagnostic Studies _____

Treatment Considerations _____

Problem #3 _____

Presenting Signs & Symptoms _____

Suggested Diagnostic Studies _____

Treatment Considerations _____

Comments on Child, Family, Caregiver, or Other Specific Medical Issues

Physician/Clinician Signature _____

Print Name Above _____

Family/Caregiver Signature Giving Consent for Release of this
Information to the Emergency Room _____

Print Name Above _____

Care Plan Part II: Child Description

Child's Name _____

Nickname _____

Date Of Birth _____

Child's Assets & Strengths _____

Vital Sign Baselines

Ht _____

Wt _____

Temp _____

Other _____

Challenges

Check all that apply, please explain on lines below.

- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> Behavioral | <input type="checkbox"/> Hearing/Vision | <input type="checkbox"/> Physical Anomalies | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Learning | <input type="checkbox"/> Sensory | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Feed & Swallowing | <input type="checkbox"/> Orthopedic/Musculoskeletal | <input type="checkbox"/> Stamina/Fatigue | <input type="checkbox"/> Other _____ |
- _____

Procedures to Be Avoided _____

Foods to Be Avoided _____

Activities to Be Avoided _____

Prior Surgeries/Procedures

_____ Date _____	_____ Date _____
_____ Date _____	_____ Date _____
_____ Date _____	_____ Date _____

Most Recent Labs/Diagnostic Studies

Labs _____

EEG _____
EKG _____
X-Rays _____

Drug Levels _____

C-Spine _____
Other _____
Other _____

MRI/CT _____

Care Plan Part II: Child Description (cont.)

Equipment/Appliances/Assistive Technology Please check all that apply and use the lines below to explain.

- | | | | | | |
|---------------------------------------|---|--|----------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Gastrostomy | <input type="checkbox"/> Nebulizer | <input type="checkbox"/> Monitors: (✓) | <input type="checkbox"/> Apnea | <input type="checkbox"/> O2 | <input type="checkbox"/> Crutches |
| <input type="checkbox"/> Tracheostomy | <input type="checkbox"/> Adaptive Seating | <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Cardiac | <input type="checkbox"/> Glucose | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Suction | <input type="checkbox"/> Communication Device | <input type="checkbox"/> Orthotics | | | <input type="checkbox"/> Other |

School System/Child Care

Contact Person/Role

Phone

Family Information

Caregivers

Siblings

Other Important Facts

Special Circumstances/Comment/What You Would Like Us to Know

Parent/Caregiver Signature & Date

Primary Care Clinician Signature & Date