Medical Summary Part I

Child's Name | **Nickname** | **DOB**

Parent *Caregiver* | Relationship

Address

Home Phone *Blocked?* ◯ *Y* ◯ *N* | Best Time to Reach | E-mail

Mother Alternate Phone | Father Alternate Phone

Emergency Contact | Phone | Relationship

Emergency Contact | Phone | Relationship

Health Insurance/Plan | Identification #

Diagnoses **Emergency Plan?** ◯ **Yes** ◯ **No** **Complexity Level**

Primary ICD9 | Primary ICD9

Secondary ICD9 | Secondary ICD9

Secondary ICD9 | Secondary ICD9

Allergies/Reaction

Medications/Dose

PCP | **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, or Other Specific Medical Issues

_____

_____

_____

_____

_____

Physician/Provider Signature _____ Print Name Above _____

Family/Guardian 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** _____ **DOB** _____

Child's Assets & Strengths _____

Vital Sign *Baselines*

Ht _____ Wt _____ Temp _____ Other _____

Challenges Check all that apply, please explain on lines below.

- ☐ Behavioral
- ☐ Communication
- ☐ Feed & Swallowing
- ☐ Hearing/Vision
- ☐ Learning
- ☐ Orthopedic/Musculoskeletal
- ☐ Physical Anomalies
- ☐ Sensory
- ☐ Stamina/Fatigue
- ☐ Respiratory
- ☐ Other _____
- ☐ 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 _____

Drug Levels _____

MRI/CT _____

EEG _____

EKG _____

X-Rays _____

C-Spine _____

Other _____

Other _____

Care Plan Part II: Child Description *(cont.)*

Equipment/Appliances/Assistive Technology

Please check all that apply and use the lines below to explain.

- ☐ Gastrostomy
- ☐ Nebulizer
- ☐ Monitors: (✓) ☐ Apnea ☐ O2 ☐ Cardiac ☐ Glucose
- ☐ Crutches
- ☐ Tracheostomy
- ☐ Adaptive Seating
- ☐ Wheelchair
- ☐ Walker
- ☐ Suction
- ☐ Communication Device
- ☐ Orthotics
- ☐ 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 Provider Signature & Date