



Child's Name	Nickname	DOB
Parent Caregiver	Relationship	
Address		
Home Phone	Blocked? <i>Y</i> <i>N</i>	Best Time to Reach
Mother Alternate Phone		E-mail
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	ICD9
Secondary	ICD9	Secondary	ICD9	ICD9
Secondary	ICD9	Secondary	ICD9	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
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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

Hearing/Vision

Physical Anomalies

Respiratory

Communication

Learning

Sensory

Other _____

Feed & Swallowing

Orthopedic/Musculoskeletal

Stamina/Fatigue

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.

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



School System/Child Care _____

Contact Person/Role _____

Phone _____

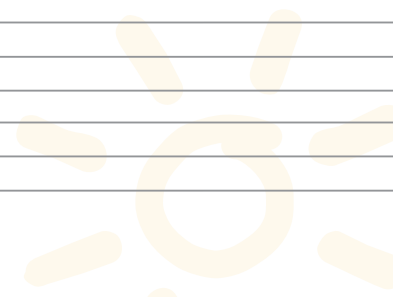
Family Information

Caregivers _____

Siblings _____

Other Important Facts _____

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



Parent /Caregiver Signature & Date

Primary Care Provider Signature & Date