Medical and Care Information

Child's Name: ____________________ DOB: _________

Home Address: ______________________________________ Home Phone: _________________

Parent/Guardian: __________________________ Work Phone _____________________ Cell Phone _______________

Parent/Guardian: __________________________ Work Phone _____________________ Cell Phone _______________

Parent/Guardian: __________________________ Work Phone _____________________ Cell Phone _______________

Emergency Contacts: ____

____

This Section is Filled Out by Medical Providers

Primary Provider: ____________________________ Phone ______________

Specialty Physicians: Phone

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Diagnoses/Problem List Interventions

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Allergies: Medication/Food/Contact

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____

 This form abstracted from the AAP "Emergency Form for Children with Special Needs" and the Medical Home Improvement Project "Care Plan"

Medical and Care Information

Child's Name: ____________________ DOB: _________

Baseline Physical Findings/Vital Signs/Neurologic Status

____
____
____
____
____
____
____
____
____

Common Presenting Medical Problems with Specific Suggested Management

Problem	Possible Diagnostic Studies	Treatment Considerations

Immunizations Up to Date as of _____________ Yes No Attached

Medication Orders

Medication	Dosage/frequency/method	Duration of Rx (start/stop dates)	Side Effects

Special or PRN instructions:

____
____
____
____

MD Signature ____________________________________ Date _______________

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Medical and Care Information

Child's Name: ____________________ DOB: ________

This Section is Filled Out by Caregivers

Equipment/appliances/assistive Technology

❐ Gastrostomy ❐ Adaptive Seating ❐ Wheelchair ❐ Tracheostomy ❐ Orthotics ❐ Suction ❐ Nebulizer
❐ Communication Device type __________________ ❐ Monitors: (✓) __Apnea __O2 __Cardiac__Glucose
Other____________________________

Family Information

Caregivers, Siblings, Other important facts

School System/Child Care Contact Person/Role Phone

Foods/Activities to be avoided

Comments

Release of Information

I authorize ____
to release and receive all pertinent information regarding my child to/from the parties named below.

(Parent/Legal Guardian) (Date)

HIPAA form completed for Health and Child Care Communication? Yes No

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