Last name:

***Instructions***

*2001-02-08 22:10:28*

--------------------------------------------

You can click on any line and enter your information, then tab to next item. Print form after completing. You can also print a blank form. Double click top left corner of this box to hide these instructions. Double click on yellow note icon in upper left corner of the first page to open again.

Emergency Information Form for Children With Special Needs

 



Date form

completed

By Whom

Revised

Revised

Initials

Initials

|  |  |
| --- | --- |
| Name: | Birth date: Nickname: |
| Home Address: | Home/Work Phone: |
| Parent/Guardian: | Emergency Contact Names & Relationship: |
| Signature/Consent\*: |  |
| Primary Language: | Phone Number(s): |
| **Physicians:** | |
| Primary care physician: | Emergency Phone: |
| Fax: |
| Current Specialty physician: Specialty: | Emergency Phone: |
| Fax: |
| Current Specialty physician: Specialty: | Emergency Phone: |
| Fax: |
| Anticipated Primary ED: | Pharmacy: |
| Anticipated Tertiary Care Center: | |

|  |  |  |
| --- | --- | --- |
| Diagnoses/Past Procedures/Physical Exam:  1 . |  | Baseline physical findings: |
|  |  |
| 2. |  |
|  |  |
| 3. | Baseline vital signs: |
|  |  |
| 4. |  |
| Synopsis: |  |
|  | Baseline neurological status: |
|  |  |
|  |  |
|  |  |

Last name:

|  |  |  |
| --- | --- | --- |
| Diagnoses/Past Procedures/Physical Exam continued:  Medications: |  | Significant baseline ancillary findings (lab, x-ray, ECG): |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. | Prostheses/Appliances/Advanced Technology Devices: |
| 5. |  |
| 6. |  |

|  |  |
| --- | --- |
| Management Data: | |
| **Allergies: Medications/Foods to be avoided** | **and why:** |
| 1. | |
| 2. | |
| 3. | |
| **Procedures to be avoided** | **and why:** |
| 1. | |
| 2. | |
| 3. | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Immunizations** | | | | | | | | | | | | |
| **Dates** |  |  |  |  |  |  | **Dates** |  |  |  |  |  |
| DPT |  |  |  |  |  | Hep B |  |  |  |  |  |
| OPV |  |  |  |  |  | Varicella |  |  |  |  |  |
| MMR |  |  |  |  |  | TB status |  |  |  |  |  |
| HIB |  |  |  |  |  | Other |  |  |  |  |  |

Antibiotic prophylaxis: Indication: Medication and dose:

|  |
| --- |
| Common Presenting Problems/Findings With Specific Suggested Managements  Problem Suggested Diagnostic Studies Treatment Considerations |
|  |
|  |
|  |

**Comments on child, family, or other specific medical issues:**

**Physician/Provider Signature:**

**Print Name:**