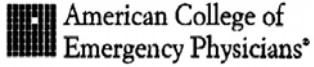


Emergency Information Form for Children With Special Needs

Last name:



American Academy of Pediatrics



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: | | Emergency Phone: | |
| Specialty: | | Fax: | |
| Current Specialty physician: | | Emergency Phone: | |
| Specialty: | | 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: _____ |
| _____ | _____ |
| _____ | _____ |

*Consent for release of this form to health care providers

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 (mm/yy) | | | | | | | | | | | |
| 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: |