Medical Summary Part I

Child's Name | **Nickname** | **Date Of Birth**

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 | Primary

Secondary | Secondary

Secondary | Secondary

Allergies/Reaction

Medications/Dose

Primary Care Clinician | **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, Caregiver, or Other Specific Medical Issues

_____

_____

_____

_____

_____

Physician/Clinician Signature _____ Print Name Above _____

Family/Caregiver 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** _____ **Date Of Birth** _____

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