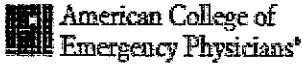


# Emergency Information Form for Children With Special Needs

Last name:



American Academy of Pediatrics



Date form completed	Revised	Initials
By Whom	Revised	Initials

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

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

\*Consent for release of this form to health care providers

Last name:

**Diagnoses/Past Procedures/Physical Exam continued:**

<b>Medications:</b>	<b>Significant baseline ancillary findings (lab, x-ray, ECG):</b>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	<b>Prostheses/Appliances/Advanced Technology Devices:</b>
5. _____	_____
6. _____	_____

**Management Data:**

<b>Allergies: Medications/Foods to be avoided</b>	<b>and why:</b>
1. _____	_____
2. _____	_____
3. _____	_____
<b>Procedures to be avoided</b>	<b>and why:</b>
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:** \_\_\_\_\_