Emergency Information Form for Children With Special Needs

Last name:

American College of Emergency Physicians*

American Academy of Pediatrics

Date form completed	Revised	Initials
By Whom	Revised	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.

2.

3.

4.

Synopsis:

Baseline physical findings:

Baseline vital signs:

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					
DPT					
OPV					
MMR					
HIB					

Dates					
Hep B					
Varicella					
TB status					
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:**