



Last name:

# Emergency Information Form for Children With Special Needs



Date form completed	Revised	Initials
By Whom	Revised	Initials

<b>Name:</b>		Birth date:	Nickname:
Home Address:		Home/Work Phone:	
Parent/Guardian:	Emergency Contact Names & Relationship:		
Signature/Consent*:			
Primary Language:	Phone Number(s):		
<b>Physicians:</b>			
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:			

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

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

**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:**

<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**

Dates						Dates					
DPT						Hep B					
OPV						Varicella					
MMR						TB status					
HIB						Other					

Antibiotic prophylaxis:	Indication:	Medication and dose:
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**Common Presenting Problems/Findings With Specific Suggested Managements**

Problem	Suggested Diagnostic Studies	Treatment Considerations

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

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<b>Physician/Provider Signature:</b>	<b>Print Name:</b>
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