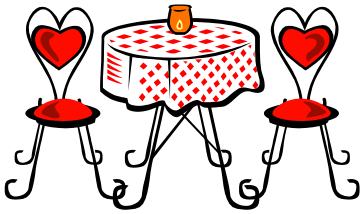
Caregiver Café



Personal Medical Home Information For

_____

This information is designed to allow parents the ability to have all of the medical information and personal information of their child in one place. This information is also useful in the event of an emergency, incapacitation or death of primary care givers. This information has been created by the primary caregiver and may be used for varying reasons decided upon by caregiver.

Insert Photo	Insert Photo	Insert Photo

Personal Information

Child:

*Name:*_____ *DOB:* _____

Address: _____

*Phone Number:*_____*Phone Number Cell:* _____

Email (if applicable): _____

Social Security #: _____

Diagnosis: _____

*Name:*_____ *DOB:* _____

Address: _____

*Phone Number:*_____*Phone Number Cell:* _____

Email (if applicable): _____

Social Security #: _____

Diagnosis: _____

*Name:*_____ *DOB:* _____

Address: _____

*Phone Number:*_____*Phone Number Cell:* _____

Email (if applicable): _____

Social Security #: _____

Diagnosis: _____

Parent/Guardian

Name:_____ DOB: _____

Address: _____

Phone Number:_____Phone Number Cell: _____

Social Security #: _____ Email: _____

Marital Status: _____Married _____ Single _____ Divorced _____Step Parent

Employment: _____ yes _____no _____ retired

If yes, Employer: _____

Legal Guardianship: _____yes _____no Name if other than parent: _____

Address:_____

Phone: _____

Name:_____ DOB: _____

Address: _____

Phone Number:_____Phone Number Cell: _____

Social Security #: _____ Email: _____

Marital Status: _____Married _____ Single _____ Divorced _____Step Parent

Employment: _____ yes _____no _____ retired

If yes, Employer: _____

Legal Guardianship: _____yes _____no Name if other than parent: _____

Address:_____

Phone: _____

Siblings w/out Special Needs

Name: _____ Female:_____ Male: _____

Phone: _____ Address: _____

DOB: _____ Biological: _____ or Step: _____ Foster: _____

****

Name: _____ Female:_____ Male: _____

Phone: _____ Address: _____

DOB: _____ Biological: _____ or Step: _____ Foster: _____

****

Name: _____ Female:_____ Male: _____

Phone: _____ Address: _____

DOB: _____ Biological: _____ or Step: _____ Foster: _____

****

Name: _____ Female:_____ Male: _____

Phone: _____ Address: _____

DOB: _____ Biological: _____ or Step: _____ Foster: _____

****

Name: _____ Female:_____ Male: _____

Phone: _____ Address: _____

DOB: _____ Biological: _____ or Step: _____ Foster: _____

Insurance Information

Life Insurance:

Child/ Youth/Young Adult

Name of Insured: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Policy #: _____ Contact:_____

****

Child/ Youth/Young Adult

Name of Insured: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Policy #: _____ Contact:_____

****

Child/ Youth/Young Adult

Name of Insured: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Policy #: _____ Contact:_____

Parent/ Guardian

Name of Insured: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Policy #: _____ Contact:_____

Retirement: _____ Employer:_____

****

Parent/ Guardian

Name of Insured: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Policy #: _____ Contact:_____

Retirement: _____ Employer:_____

****

Health Insurance:

Child/ Youth/Young Adult

Primary Insurance:_____

Policy#:_____ Group#: _____

Contact Address: _____

Phone #: _____ Dental: _____ yes _____no Vision: _____yes _____no

Secondary Insurance: _____

Policy/ Medicaid/ Medicare: _____

Medicaid/Medicare #: _____ Policy #: _____

Contact: _____ Phone #: _____

Child/ Youth/Young Adult

*Primary Insurance:*_____

*Policy#:*_____ *Group#:* _____

Contact Address: _____

Phone #: _____ *Dental:* _____ *yes* _____*no* *Vision:* _____*yes* _____*no*

Secondary Insurance: _____

Policy/ Medicaid/ Medicare: _____

Medicaid/Medicare #: _____ *Policy #:* _____

Contact: _____ *Phone #:* _____

****

Child/ Youth/Young Adult

*Primary Insurance:*_____

*Policy#:*_____ *Group#:* _____

Contact Address: _____

Phone #: _____ *Dental:* _____ *yes* _____*no* *Vision:* _____*yes* _____*no*

Secondary Insurance: _____

Policy/ Medicaid/ Medicare: _____

Medicaid/Medicare #: _____ *Policy #:* _____

Contact: _____ *Phone #:* _____

Special Notations:

Parent/ Guardian

*Primary Insurance:*_____

*Policy#:*_____ *Group#:* _____

Contact Address: _____

Phone #: _____ *Dental:* _____ *yes* _____*no* *Vision:* _____*yes* _____*no*

Secondary Insurance: _____

Policy/ Medicaid/ Medicare: _____

Medicaid/Medicare #: _____ *Policy #:* _____

Contact: _____ *Phone #:* _____

****

*Primary Insurance:*_____

*Policy#:*_____ *Group#:* _____

Contact Address: _____

Phone #: _____ *Dental:* _____ *yes* _____*no* *Vision:* _____*yes* _____*no*

Secondary Insurance: _____

Policy/ Medicaid/ Medicare: _____

Medicaid/Medicare #: _____ *Policy #:* _____

Contact: _____ *Phone #:* _____

Special Notations:

Financial Holdings

Child/Youth/ Young Adult

Savings Account: _____ yes _____ no Account # _____

Bank Name: _____ Phone#: _____

Address: _____

Beneficiaries Names: _____

_____

Checking Account: _____ yes _____ no Account # _____

Bank Name: _____ Phone#: _____

Address: _____

Beneficiaries Names: _____

_____

Special Needs Trust: _____yes ____no Tax ID #: _____

Establishment/Bank/Holder's Name: _____

_____ Location Kept: _____

Beneficiaries Names: _____

_____

Trustees/Co-Trustees Names: _____

_____

Other Financial Documents and Holdings:

_____

_____

Child/Youth/ Young Adult

Savings Account: _____ yes _____ no Account # _____

Bank Name: _____ Phone#: _____

Address: _____

Beneficiaries Names: _____

_____

Checking Account: _____ yes _____ no Account # _____

Bank Name: _____ Phone#: _____

Address: _____

Beneficiaries Names: _____

_____

Special Needs Trust: _____yes ____no Tax ID #: _____

Establishment/Bank/Holder's Name: _____

_____Location Kept: _____

Beneficiaries Names: _____

_____

Trustees/Co-Trustees Names: _____

_____

Other Financial Documents and Holdings: _____

_____

_____

_____

Child/Youth/ Young Adult

Savings Account: _____ yes _____ no Account # _____

Bank Name: _____ Phone#: _____

Address: _____

Beneficiaries Names: _____

_____

Checking Account: _____ yes _____ no Account # _____

Bank Name: _____ Phone#: _____

Address: _____

Beneficiaries Names: _____

_____

Special Needs Trust: _____yes ____no Tax ID #: _____

Establishment/Bank/Holder's Name: _____

_____Location Kept: _____

Beneficiaries Names: _____

_____

Trustees/Co-Trustees Names: _____

_____

Other Financial Documents and Holdings: _____

_____

_____

_____

Parents/Guardian

Savings Account: _____ yes _____ no Account # _____

Bank Name: _____ Phone#: _____

Address: _____

Beneficiaries Names: _____

_____

Checking Account: _____ yes _____ no Account # _____

Bank Name: _____ Phone#: _____

Address: _____

Beneficiaries Names: _____

_____

IRA/401K/Retirement: _____yes _____ no

Account #: _____ Account#: _____

Employer Coverage: _____yes _____no Account#: _____

Institution: _____

Beneficiaries Names: _____

US Savings Bonds: _____yes ____ no Kept: _____

Beneficiaries Names: _____

Stocks: ___yes _____ no

Broker:

_____

Other: _____

Parents/Guardian

Savings Account: _____ yes _____ no Account # _____

Bank Name: _____ Phone#: _____

Address: _____

Beneficiaries Names: _____

_____

Checking Account: _____ yes _____ no Account # _____

Bank Name: _____ Phone#: _____

Address: _____

Beneficiaries Names: _____

_____

IRA/401K/Retirement: _____yes _____ no

Account #: _____ Account#: _____

Employer Coverage: _____yes _____no Account#: _____

Institution: _____

Beneficiaries Names: _____

US Savings Bonds: _____yes ____ no Kept: _____

Beneficiaries Names: _____

Stocks: ___yes _____ no

Broker:

_____

Other: _____

Government/Local Programs

Child/ Youth/ Young Adult

Receive SSI/SSDI: ____yes ____no Amount: _____ Amount: _____

Home and Community Based Waivers: _____

Case Manager: _____ Social Worker:_____

Vocational Rehab: ____yes ____no Case Worker: _____

Phone #: _____

Housing: ____yes ____no Contact: _____

Food Stamps: ____yes ____no Heating Assistance: _____yes _____no

Respite/Caregiver: _____ Address: _____

Agency: _____ Phone #: _____

Email: _____

Other Community/ Recreation Programs:

Child/ Youth/ Young Adult

Receive SSI/SSDI: ____yes ____no Amount: _____ Amount: _____

Home and Community Based Waivers: _____

Case Manager: _____ Social Worker:_____

Vocational Rehab: ____yes ____no Case Worker: _____

Phone #: _____

Housing: ____yes ____no Contact: _____

Food Stamps: ____yes ____no Heating Assistance: _____yes _____no

Respite/Caregiver: _____ Address: _____

Agency: _____ Phone #: _____

Email: _____

Other Community/ Recreation Programs:

Child/ Youth/ Young Adult

Receive SSI/SSDI: ____yes ____no Amount: _____ Amount: _____

Home and Community Based Waivers: _____

Case Manager: _____ Social Worker:_____

Vocational Rehab: ____yes ____no Case Worker: _____

Phone #: _____

Housing: ____yes ____no Contact: _____

Food Stamps: ____yes ____no Heating Assistance: _____yes _____no

Respite/Caregiver: _____ Address: _____

Agency: _____ Phone #: _____

Email: _____

Other Community/ Recreation Programs:

Therapy

Child/Youth/Young Adult

Speech Therapy: _____yes _____ no Institution Name: _____

Therapist Name:_____ Phone #: _____

Email: _____

Occupational Therapy: ____yes ___no Institution Name: _____

Therapist Name: _____ Phone # :_____

Email: _____

Physical Therapy: ___yes ____no Institution Name: _____

Therapist Name: _____ Phone #: _____

Email: _____

Other Therapy:

Name: _____ Phone#: _____

Name: _____ Phone#: _____

Name: _____ Phone#: _____

Name: _____ Phone#: _____

Psychologist/Psychiatrist

Name: _____ Phone# : _____

Email: _____

Name: _____ Phone# : _____

Email: _____

Child/Youth/Young Adult

Speech Therapy: _____yes _____ no Institution Name: _____

Therapist Name:_____ Phone #: _____

Email: _____

Occupational Therapy: ____yes ___no Institution Name: _____

Therapist Name: _____ Phone # :_____

Email: _____

Physical Therapy: ___yes ____no Institution Name: _____

Therapist Name: _____ Phone #: _____

Email: _____

Other Therapy:

Name: _____ Phone#: _____

Name: _____ Phone#: _____

Name: _____ Phone#: _____

Name: _____ Phone#: _____

Psychologist/Psychiatrist

Name: _____ Phone# : _____

Email: _____

Name: _____ Phone# : _____

Email: _____

Child/Youth/Young Adult

Speech Therapy: _____yes _____ no Institution Name: _____

Therapist Name:_____ Phone #: _____

Email: _____

Occupational Therapy: ____yes ___no Institution Name: _____

Therapist Name: _____ Phone # :_____

Email: _____

Physical Therapy: ___yes ____no Institution Name: _____

Therapist Name: _____ Phone #: _____

Email: _____

Other Therapy:

Name: _____ Phone#: _____

Name: _____ Phone#: _____

Name: _____ Phone#: _____

Name: _____ Phone#: _____

Psychologist/Psychiatrist

Name: _____ Phone# : _____

Email: _____

Name: _____ Phone# : _____

Email: _____

Medical History

Child/Youth/ Young Adult

Brief Description of Diagnosis/Chronic Health/ Disability: Resuscitation: _____yes _____no

*Current Diagnosis:*_____

_____

Medications: Current

Name: _____ *Dosage*_____ | *Name:*_____ *Dosage*_____

Name: _____ *Dosage*_____ | *Name:*_____ *Dosage*_____

Name: _____ *Dosage*_____ | *Name:*_____ *Dosage*_____

Name: _____ *Dosage*_____ | *Name:*_____ *Dosage*_____

Name: _____ *Dosage*_____ | *Name:*_____ *Dosage*_____

Surgeries/Procedures:

_____ *Date:*_____

_____ *Date:*_____

_____ *Date:*_____

_____ *Date:*_____

_____ *Date:*_____

_____ *Date:*_____

_____ *Date:*_____

Allergies: _____ *Reaction:* _____

Allergies: _____ *Reaction:* _____

Allergies: _____ *Reaction:* _____

Allergies: _____ *Reaction:* _____

Physicians:

Doctor: _____ *Medical Group:* _____

Address: _____ *Phone#:* _____

Specialty: _____

*Doctor:*_____ *Medical group:*_____

Address: _____ *Phone#:* _____

Specialty: _____

*Doctor:*_____ *Medical group:*_____

Address: _____ *Phone#:* _____

Specialty: _____

*Doctor:*_____ *Medical group:*_____

Address: _____ *Phone#:* _____

Specialty: _____

Child/Youth/ Young Adult

Brief Description of Diagnosis/Chronic Health/ Disability: Resuscitation _____yes _____no

*Current Diagnosis:*_____

_____

Medications: Current

Name: _____ *Dosage*_____ | *Name:*_____ *Dosage*_____

Name: _____ *Dosage*_____ | *Name:*_____ *Dosage*_____

Name: _____ *Dosage*_____ | *Name:*_____ *Dosage*_____

Name: _____ *Dosage*_____ | *Name:*_____ *Dosage*_____

Name: _____ *Dosage*_____ | *Name:*_____ *Dosage*_____

Surgeries/Procedures:

_____ *Date:*_____

_____ *Date:*_____

_____ *Date:*_____

_____ *Date:*_____

_____ *Date:*_____

_____ *Date:*_____

_____ *Date:*_____

Allergies: _____ *Reaction:* _____

Allergies: _____ *Reaction:* _____

Allergies: _____ *Reaction:* _____

Allergies: _____ *Reaction:* _____

Physicians:

Doctor: _____ *Medical Group:* _____

Address: _____ *Phone#:* _____

Specialty: _____

*Doctor:*_____ *Medical group:*_____

Address: _____ *Phone#:* _____

Specialty: _____

*Doctor:*_____ *Medical group:*_____

Address: _____ *Phone#:* _____

Specialty: _____

*Doctor:*_____ *Medical group:*_____

Address: _____ *Phone#:* _____

Specialty: _____

Child/Youth/ Young Adult

Brief Description of Diagnosis/Chronic Health/ Disability: Resuscitation: ____yes _____no

*Current Diagnosis:*_____

_____

Medications: Current

Name: _____ *Dosage*_____ *Name:*_____ *Dosage*_____

Name: _____ *Dosage*_____ *Name:*_____ *Dosage*_____

Name: _____ *Dosage*_____ *Name:*_____ *Dosage*_____

Name: _____ *Dosage*_____ *Name:*_____ *Dosage*_____

Surgeries/Procedures:

_____ *Date:*_____

_____ *Date:*_____

_____ *Date:*_____

_____ *Date:*_____

_____ *Date:*_____

_____ *Date:*_____

_____ *Date:*_____

Allergies: _____ *Reaction:* _____

Allergies: _____ *Reaction:* _____

Allergies: _____ *Reaction:* _____

Allergies: _____ *Reaction:* _____

Physicians:

Doctor: _____ *Medical Group:* _____

Address: _____ *Phone#:* _____

Specialty: _____

*Doctor:*_____ *Medical group:*_____

Address: _____ *Phone#:* _____

Specialty: _____

*Doctor:*_____ *Medical group:*_____

Address: _____ *Phone#:* _____

Specialty: _____

*Doctor:*_____ *Medical group:*_____

Address: _____ *Phone#:* _____

Specialty: _____

Medical History

Parent/Guardian

Current Physicians:

*Doctor:*_____ *Medical group:*_____

Address: _____ *Phone#:* _____

Specialty: _____

*Doctor:*_____ *Medical group:*_____

Address: _____ *Phone#:* _____

Specialty: _____

*Doctor:*_____ *Medical group:*_____

Address: _____ *Phone#:* _____

Specialty: _____

Brief on any Medical History and Family History

*Surgeries:*_____*Date:* _____

_____ *Date:* _____

_____ Date: _____

_____ *Date:* _____

Resuscitation: _____yes _____no Life Support Means: _____yes _____no

Current Medications:

Name: _____ Dosage_____ Name:_____ Dosage_____

Name: _____ Dosage_____ Name:_____ Dosage_____

Living Will _____yes _____no Location: _____

Administrator: _____ Phone: _____

Address: _____

Email: _____

Power Of Attorney: _____

Directions/ Last Wishes

Parent/Guardian

Current Physicians:

*Doctor:*_____ *Medical group:*_____

Address: _____ *Phone#:* _____

Specialty: _____

*Doctor:*_____ *Medical group:*_____

Address: _____ *Phone#:* _____

Specialty: _____

*Doctor:*_____ *Medical group:*_____

Address: _____ *Phone#:* _____

Specialty: _____

Brief on any Medical History and Family History

*Surgeries:*_____*Date:* _____

_____ *Date:* _____

_____ Date: _____

_____ *Date:* _____

Resuscitation: _____*yes* _____*no* *Life Support Means:* _____*yes* _____*no*

Current Medications:

Name: _____ Dosage_____ Name:_____ Dosage_____

Name: _____ Dosage_____ Name:_____ Dosage_____

Living Will _____yes _____no Location: _____

Administrator: _____ Phone: _____

Address: _____

Email: _____

Power Of Attorney: _____

Directions/ Last Wishes

All About _____

The following pages are designed for you to fill in with as much personal information about your child. The more information you include the better. This way anyone who uses this book can get a complete picture of your child. This portion needs to be updated as child grows.

Favorite Things:

How I Communicate

What I Need Help With

Things I do not Like

Things I do Like

List my Strengths

List my Weaknesses

What I Want for Me

_____ ***Safety***

Describe Medical Conditions

All Emergency Protocols

From My Parents

List of my parents " village" (people that we trust and know will support me)

Name:_____ Phone# _____

Address: _____

Email: _____

Description: _____

_____

Name:_____ Phone# _____

Address: _____

Email: _____

Description: _____

_____

Name:_____ Phone# _____

Address: _____

Email: _____

Description:_____

_____

Name:_____ Phone# _____

Address: _____

Email: _____

Description: _____

Name:_____ Phone# _____

Address: _____

Email: _____

Description: _____

_____

Name:_____ Phone# _____

Address: _____

Email: _____

Description: _____

_____

Name:_____ Phone# _____

Address: _____

Email: _____

Description: _____

_____

Name:_____ Phone# _____

Address: _____

Email: _____

Description: _____

_____

It's not easy to describe the experience of raising a child with special needs. From the outside, it may look challenging and stressful. But in the heart of a parent, it is a wonderful experience of evolution and personal growth.

Parents of kids with special needs don't see a disability when they look at their kids. Instead, they see the most precious and wonderful blessing of their lives. They see their child.

We share our life experiences, our kids' smiles and their achievements, not as a way to convince ourselves and others of their perfection, but simply as parents whose children are their pride and joy. We talk about our kids' disabilities not to label them, but to make others aware of all our similarities and the great efforts our children make to achieve their goals.

Still, even the most resilient of parents needs some inspiration and reassurance sometimes. These quotes were not specifically created to explain the experience of raising a child with special needs, but they are a good reminder to all of us to see the beauty, joy and hope in our everyday lives with our children.

"I always knew looking back on the tears, would make me laugh,

But I never knew looking back on the laughs would make me cry"

Eliana Tardio

<u>Family Picture</u>