Care Notebook

Please accept this copy of the FVND Care Notebook.

You may copy the pages for your use.

Please direct any comments, suggestions or questions to:

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Family Voices of North Dakota
P.O. Box 163
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FVND Care Notebook: A Quick Guide

What is a Care Notebook?

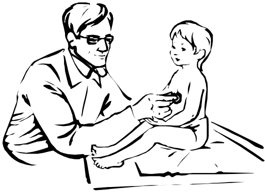
A Care Notebook is an organizing tool for families who have children with special health care needs or disabilities. Use a Care Notebook to keep track of important information about your child's health care. This Care Notebook has been designed for families living in North Dakota.

How can a Care Notebook help me?

In caring for your child with special health needs and/or disabilities, you may get information and paperwork from many sources. A Care Notebook helps you organize the most important information in a central place. A Care Notebook makes it easier for you to find and share key information with others who are part of your child's care team.

Use your Care Notebook to:

- Track changes in your child's medicines or treatments
- List telephone numbers for health care providers and community organizations
- Prepare for appointments
- File information about your child's health history
- Share new information with your child's primary doctor, public health or school nurse, daycare staff, and others caring for your child



What are some helpful hints for using my child's Care Notebook?

- Store the Care Notebook where it is easy to find. This helps you and anyone who needs information when you are not there.
- Add new information to the Care Notebook whenever your child's treatment changes.
- Consider taking the Care Notebook with you to appointments and hospital visits so that information you need will be easy to find.

Supported with funding from ND Department of Human Services, Medical Services Division, Children's Special Health Services and Centers for Medicare and Medicaid Services 11-P-92506/8-01

Setting up Your Care Notebook

Follow these steps to set up your **child's notebook:**

Step 1: Gather information you already have.

- Gather up any health information about your child you already have. This may include reports from recent doctor's visits, recent summary of a hospital stay, this year's school plan, test results, or informational pamphlets.

Step 2: Look through the pages of the Care Notebook.

- Which of these pages could help you keep track of information about your child's health or care?
- Choose the pages you like. Print copies of any that you think you will use. The Care Notebook pages are available from the Internet at www.geocities.com/ndfv/ Go to Resources Page and choose the "Care Notebook."

Step 3: Decide which information about your child is most important to keep in the Care Notebook.

- What information do you look up often?
- What information do people caring for your child need?
- Consider storing other information in a file drawer or box where you can find it if needed.

Step 4: Put the Care Notebook together.

- Everyone has a different way of organizing information. The only important thing is to make it easy for <u>you</u> to find again. Here are some suggestions for supplies used to create a Care Notebook:
- 3-ring notebook or large accordion envelope. Hold papers securely.
- Tabbed dividers. Create your own information sections.
- Pocket dividers. Store reports.
- Plastic pages. Store business cards and photographs.

FVND Care Notebook
List of Pages

Pages to Keep Track of
Appointments and Care

- ☼ Appointment Log
- ☼ Diet Tracking Form
- ☼ Equipment
- ☼ Supplies
- ☼ Growth Tracking Form
  - ☼ Growth Charts
- ☼ Hospital Stay Tracking Form
- ☼ Information Needed by Emergency Care Providers
- ☼ Lab Work/Tests/Procedures
- ☼ Medical Bill Tracking Form
- ☼ Medical Surgical Highlights
- ☼ Medications
- ☼ Notes

Pages to Create a Care Summary:
Abilities and Special Care Needs

- ☼ Activities of Daily Living
- ☼ Care Schedule
- ☼ Child's Page
- ☼ Communication
- ☼ Coping/Stress Tolerance
- ☼ Mobility
- ☼ Nutrition
- ☼ Respiratory
- ☼ Rest/Sleep
- ☼ Social/Play
- ☼ Transitions

Pages to Create a Care Team
Resource List

Community Health Care/Service Providers:

- ☼ Medical / Dental
- ☼ Public Health
- ☼ Home Care
- ☼ Therapists
- ☼ Early Intervention Services
- ☼ School
- ☼ Child Care
- ☼ Respite Care
- ☼ Pharmacy
- ☼ Special Transportation
- ☼ Recreation Opportunities

- ☼ Family Information
- ☼ Family Support Resources
- ☼ Funding Sources

Note: You may use all or just a part of these pages. Not all of the pages may apply to your family situation. For example, your child may be over age 3, and therefore not involved in Early Intervention.

Organize your pages any way that works for you. (See "Setting up Your Care Notebook.")

Use dividers or tabs to help you organize your notebook. Sheet protectors, plastic pages and folders will also be helpful in organizing material.

Appointment Log

Steps to a satisfactory medical appointment:
1. Write down your problems/questions before you go.
2. Number the problems in questions. Make the number one the most important.
3. Show the provider your list. Write down any answers to your questions.
4. Talk to the provider about options for handling your problems/questions.

DATE	PROVIDER	QUESTIONS / PROBLEMS TO BE DISCUSSED	REASON SEEN / CARE PROVIDED	NEXT APPOINTMENT

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Diet Tracking Form

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRI DAY	SATURDAY
Tube Feeding							
Breakfast							
Lunch							
Dinner							
Snacks							
Notes							

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Equipment

☼ Medical Equipment Supplier (DME Supplier): ______________________________
Contact Person: ______________________________ ___________________________
Phone: __________________ Fax: ___________________ E-Mail: _________________
Contact Person: ______________________________ ___________________________
Phone: __________________ Fax: ___________________ E-Mail: _________________
Address: ____
____
Notes (delivery schedule, order schedule, etc.): ___________________________
____
____
____

☼ Name of Equipment:____

Description (brand name, size, etc.): ____

____

Date Obtained: __________________________ Service Schedule: ___________________

Contact Person: __________________________ Phone: ___________________________

☼ Name of Equipment: ____

Description (brand name, size, etc.): ____

____

Date Obtained: __________________________ Service Schedule: ___________________

Contact Person: __________________________ Phone: ___________________________

☼ Name of Equipment: ____

Description (brand name, size, etc.): ____

____

Date Obtained: __________________________ Service Schedule: ___________________

Contact Person: __________________________ Phone: ___________________________

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Supplies

☼ Medical Equipment Supplier (DME Supplier): ___________________________________
Contact Person: ______________________________ ___________________________
Phone: __________________ Fax: ___________________ E-Mail: _________________
Contact Person: ______________________________ ___________________________
Phone: __________________ Fax: ___________________ E-Mail: _________________
Address: ____
____
Notes (delivery schedule, order schedule, etc.): ____________________________________
____
____
____

ITEM	*DESCRIPTION*	*QUANTITY*	*NOTES*

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Growth Tracking Form

DATE	HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	CHECKED BY

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Hospital Stay Tracking Form

DATE	HOSPITAL	REASON	NOTES

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Emergency Preparedness for Children with Special Health Care Needs
Instructions for Parents

Dear Parent:

Children with special health care needs have very unique medical histories and require very special medical treatment. If an emergency physician does not have access to this important information, these children are in danger of delayed treatment, unnecessary tests, and even serious errors. It is extremely important, then, that parents and physicians work together to give emergency physicians access to the special information they need to properly care for children with very special health care needs.

To address this problem, the American Academy of Pediatrics and the American College of Emergency Physicians have developed the Emergency Information Form. This simple form is used to record health information for children with special health care needs and should kept in multiple locations for easy access by physicians and emergency medical personnel.

To complete this important form, follow these easy instructions:

1. GET THE FORM: Get the Emergency Information Form from the child's primary care physician, specialist, or the local emergency room.
2. FILL IT OUT: Begin filling out the form to the best of your ability. Take the form to the child's primary care physician or specialist and ask them to finish filling out the form.
3. KEEP IT: Keep 1 copy of the form in each of the following places:
   a. DOCTORS: On file with each of the child's physicians, including specialists.
   b. ER: On file with the local emergency rooms where the child is most likely to be treated in the case of an emergency.
   c. HOME: At the child's home in a place where it can be easily found, such as the refrigerator.
   d. VEHICLES: In each parent's vehicle (i.e., glove compartment).
   e. WORK: At each parent's workplace.
   f. PURSE/WALLET: In each parent's purse or wallet.
   g. SCHOOL: On file with the child's school, such as in the school nurse's office.
   h. **CHILD'S BELONGINGS:** With the child's belongings when traveling.
   i. EMERGENCY CONTACT PERSON: At the home of the emergency contact person listed on the form.
4. REGISTER: Consider registering the child, if he or she is not already registered, with Medic Alert®. Send Medic Alert® a copy of the form so that they can keep it stored in their central database, which is easily accessible by emergency medical personnel.
5. UPDATE: It is extremely important that you update the form every 2-3 years, and after any of the following events:
   a. Important changes in the child's condition.
   b. The performance of any major procedure.
   c. Important changes in the treatment plan.
   d. Changes in physicians.

Now, if your child ever has an emergency, the emergency medical personnel will have easy access to your child's very unique medical history, allowing them to provide your child with the best medical care available.

Thank you for your cooperation!

Very truly yours,
American Academy of Pediatrics
American College of Emergency Physicians
Emergency Medical Services for Children

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American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL, 60007, 847-434-4000

Emergency Information Form for Children With Special Needs

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.	Baseline physical findings:
2.	
3.	Baseline vital signs:
4.	
Synopsis:	
	Baseline neurological status:

*Consent for release of this form to health care providers

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Diagnoses/Past Procedures/Physical Exam continued:

Medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Significant baseline ancillary findings (lab, x-ray, ECG):

Prostheses/Appliances/Advanced Technology Devices:

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:

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Lab Work / Tests / Procedures

DATE	TEST	RESULT	COMMENTS

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Medical Bill Communication Log

Information About the Bill				Information About Who You Talk To					NOTES
Account #	Provider	Date of Service	What bill is for:	Date of Contact	Time	Name	Title (like Account Representative)	Credentials (RN, Dr., none)	

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Medical / Surgical Highlights

DATE	PROCEDURE	RESULT	COMMENTS

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Medications

Allergies: ____

____

Pharmacy: ____

Address: ______________________________ Phone: ______________________________

______________________________ Fax: ______________ E-Mail: ______________________

DATE STARTED	DATE STOPPED	MEDICATION	WHAT IT IS FOR	DOSE/ROUTE	TIME GIVEN	PRESCRIBED BY	SIDE EFFECTS

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Activities of Daily Living

Use this page to talk about your child's abilities to feed him or herself, bathe, get dressed, use the bathroom, comb hair, brush teeth, etc. Describe what your child can do by him or herself and any help or equipment your child uses for these activities. Describe any special routines your child has for bath time, getting dressed, etc.

Date: ______________________________

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Care Schedule

TIME	CARE
Morning	
Afternoon	

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Care Schedule

TIME	CARE
Evening	
Night	

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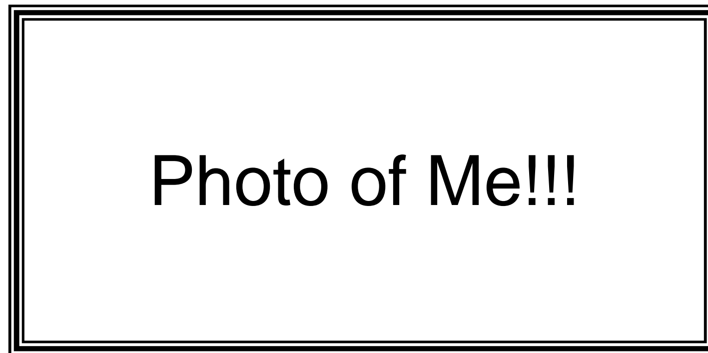
Child's Page



My name is: ______

My nickname is: ______

My pet is a: ______ My **pet's name is**: ______

My "favorites"

Toys: ______

Animal: ______

Games: ______

Hobbies: ______

Songs: ______

T.V. Shows: ______

Other: ______

______

My favorite foods are: ______

______

My least favorite foods are: ______

______

My friends' names are: ______

When I am happy I: ______

When I am sad I: ______

When I feel pain I: ______

Things I need help with (like washing, dressing or brushing teeth): ______

______

Things I can do for myself (but thanks for asking!): ______

______

If you need to know something else, ask me or ask: ______

who can be reached by calling: (   ) ______

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Child's Page

Use this page for your child's words and thoughts about his or her life now as well as later.

Date: ____________________________

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Communication

Use this page to talk about your child's ability to communicate and to understand others. Describe how your child communicates. Include sign language words, gestures, or any equipment or help your child uses to communicate or understand others. Include any special words your family and child use to describe things.

Date: ______________________________

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Coping / Stress Tolerance

Use this page to talk about how your child copes with stress. Stressful events might include new people or situations, a hospital stay, or procedures such as having blood drawn. Describe what things upset your child and what your child does when upset or when he or she has "had enough." Describe your child's way of asking for help and things to do or say to comfort your child.

Date: ______________________________

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Mobility

Use this page to talk about your child's ability to get around. Describe how your child gets around. Include what your child can do by him or herself and any help or equipment your child uses to get around. Describe any activity limits and any special routines your child has for transfers, pressure releases, positioning, etc.

Date: ______________________________

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Nutrition

Use this page to talk about your child's nutritional needs. Describe foods and any nutritional formulas your child takes, any food allergies or restrictions, and any special feeding techniques, precautions, or equipment used for feedings. Describe any special mealtime routines your family and child have.

Date: ______________________________

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Respiratory

Use this page to talk about your child's respiratory care needs. Describe the care or treatments your child needs and any special techniques or precautions you use when giving care. Include any special routines your child has for respiratory care.

Date: ______________________________

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Rest / Sleep

Use this page to talk about your child's ability to get to sleep and to sleep through the night. Describe your child's bedtime routine and any security or comfort objects your child uses.

Date: ______________________________

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Social / Play

Use this page to talk about your child's ability to get along with others. Describe how your child shows affection, shares feelings, or plays with other children. Describe what works best to help your child get along or cooperate with others. Describe your child's favorite things to do. Include any special family activities or customs that are important.

Date: ______________________________

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Transitions - Looking Ahead

Your child and family will experience many transitions, small and large, over time. Three predictable transitions occur for most children: reaching school age, approaching adolescence, and moving from adolescence into adulthood. Many children do not experience these transitions in the way most children experience them. Other transitions may involve moving into new programs, working with new agencies and care providers, or making new friends. Transitions involve changes: adding new expectations, responsibilities, or resources, and letting go.

Looking at transitions may be hard, depending on your circumstances. You may have limited time just to do what needs to get done today. You may find it helpful, though, to jot down a few ideas about your child's and family's future. You might start by thinking about your child's and family's strengths. How can these strengths help you plan for "what's next" and for reaching long-term goals? What are your dreams and your fears about your child's and family's future?

Date: ______________________________

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Medical / Dental
Community Health Care Providers

☼ Primary / Community Care Provider: ____
Date of First Visit: ____
Office Nurse/Medical Assistant: ____
Address: ____
____
Phone: ________________ Fax: ________________ E-Mail: ________________

☼ Primary Children's Medical Center
Medical Record Number: ____
Address: ____
____
Phone: ________________ Fax: ________________

☼ Community or Specialty Hospital: ____
Medical Record Number: ____
Address: ____
____
Phone: ________________ Fax: ________________

☼ Community Specialty Care Provider: ____
Specialty: ____________________Date of First Visit: ________________________
Office Nurse/Medical Assistant: ____
Address: ____
Phone: ________________ Fax: ________________ E-Mail: ________________

☼ Community Specialty Care Provider: ____
Specialty: ____________________Date of First Visit: ________________________
Office Nurse/Medical Assistant: ____
Address: ____
Phone: ________________ Fax: ________________ E-Mail: ________________

☼ Dental Provider: ____
Date of First Visit: ____
Address: ____
Phone: ________________ Fax: ________________ E-Mail: ________________

☼ Orthodontist: ____
Date of First Visit: ____
Address: ____
Phone: ________________ Fax: ________________ E-Mail: ________________

There is space to list more Specialty Care Providers on the next page.

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Providers (Continued)

Many specialty physicians may treat your child. You may keep track of some them here:

☼ Community Specialty Care Provider: ____
Specialty: ______________________Date of First Visit: ______________________________
Office Nurse/Medical Assistant: ____
Address: ____
Phone: __________________ Fax: ___________________ E-Mail: _____________________

☼ Community Specialty Care Provider: ____
Specialty: ______________________Date of First Visit: ______________________________
Office Nurse/Medical Assistant: ____
Address: ____
Phone: __________________ Fax: ___________________ E-Mail: _____________________

☼ Community Specialty Care Provider: ____
Specialty: ______________________Date of First Visit: ______________________________
Office Nurse/Medical Assistant: ____
Address: ____
Phone: __________________ Fax: ___________________ E-Mail: _____________________

☼ Community Specialty Care Provider: ____
Specialty: ______________________Date of First Visit: ______________________________
Office Nurse/Medical Assistant: ____
Address: ____
Phone: __________________ Fax: ___________________ E-Mail: _____________________

☼ Community Specialty Care Provider: ____
Specialty: ______________________Date of First Visit: ______________________________
Office Nurse/Medical Assistant: ____
Address: ____
Phone: __________________ Fax: ___________________ E-Mail: _____________________

☼ Community Specialty Care Provider: ____
Specialty: ______________________Date of First Visit: ______________________________
Office Nurse/Medical Assistant: ____
Address: ____
Phone: __________________ Fax: ___________________ E-Mail: _____________________

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Home Care Providers

☼ Home Care Agency: ____

Start Date: ____

Case Manager: ____

Other Contacts (scheduler, billing, etc.): _____________________________

Primary Care Nurse: ____

Phone: ____________________ Fax: _________________ E-Mail: __________________

☼ Home Care Agency: ____

Start Date: ____

Case Manager: ____

Other Contacts (scheduler, billing, etc.): _____________________________

Primary Care Nurse: ____

Phone: ____________________ Fax: _________________ E-Mail: __________________

☼ Home Care Agency: ____

Start Date: ____

Case Manager: ____

Other Contacts (scheduler, billing, etc.): _____________________________

Primary Care Nurse: ____

Phone: ____________________ Fax: _________________ E-Mail: __________________

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Therapists

☼ Occupational Therapist (OT):____

Start Date: ____

Agency / Hospital / Clinic: ____

Address: ____

____

Phone: _________________ Fax: _________________ E-Mail: __________________

☼ Physical Therapist (PT):____

Start Date: ____

Agency / Hospital / Clinic: ____

Address: ____

____

Phone: _________________ Fax: ________________ _ E-Mail: __________________

☼ Speech-Language Pathologist:____

Start Date: ____

Agency / Hospital / Clinic: ____

Address: ____

____

Phone: _________________ Fax: _________________ E-Mail: __________________

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Early Intervention

☼ The Early Intervention Program Early intervention means early assistance. Here in North Dakota, a special kind of partnership between parents and professionals gives every child the best possible start in life. The Department of Human Services' Infant Development/Early Intervention programs are designed to help your child and your family gets the supports you want and need. This program is designed to identify children at risk in the earliest stages, when the right help can make all the difference. This program is to support eligible children and families in enhancing a child's potential growth and development from birth to age three.

☼ My Early Intervention Program agency: ________________________________
Date contacted: ______________________ Date started in program: ________________
Service Coordinator: ____
Service Providers (therapist, nurse, etc.): _______________________________________
Address: ____
____
Phone: __________________ Fax: ________________ E-Mail: __________________
Schedule: ____
____

If you live in this Region:	Contact this Agency:	At this Telephone Number:
Williston	Northwest Human Service Center	701-774-4600
Minot	Minot State University	701-858-3054
Devils Lake	Lake Region Kids	701-662-6324
Grand Forks	Northeast Human Service Center	701-795-3000
Fargo	Southeast Human Service Center	701-298-4500
Jamestown	South Central Human Service Center	701-253-6300
Bismarck	Bismarck Early Childhood Education Program	701-221-3490
Dickinson	K.I.D.S.	701-483-4394

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School Contacts

☼ School District: ____
Address: ____

____
Phone: ________________ Fax: ______________ Web Site: _______________

Special Education Coordinator: _____________________________________
Address: ____
Phone: ________________ Fax: ______________ E-Mail: _________________

504 Accommodation Plan Coordinator (if different from above): ____________________
Address: ____
Phone: ________________ Fax: ______________ E-Mail: _________________

District Nurse assigned to your child's school: ___________________________
Address: ____
Phone: ________________ Fax: ______________ E-Mail: _________________

☼ School / Preschool: ____
Address: ____
Phone: ________________ Fax: ______________ Web Site: _______________

Principal / Administrator: ____
Phone: ________________ Fax: ______________ E-Mail: _________________

Classroom Teacher: ____
Phone: ________________ Fax: ______________ E-Mail: _________________

Resource Instructor: ____
Phone: ________________ Fax: ______________ E-Mail: _________________

Aide / Assistant / Intervener:

____
Phone: ________________ Fax: ______________ E-Mail:

____

(Some parents store IEP and 504 plan information in sheet protectors following this section.)

Special Education Director / Teacher(s):

____
Phone: ________________ Fax: ______________ E-Mail: _________________

Therapist(s): ____
Phone: ________________ Fax: ______________ E-Mail: _________________

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Other Contacts: ____

____

Child Care

☼ Child Care Provider: ____

Start Date: ______________________________

Contact Person: ____

Address: ____

____

Phone: ___________ Fax: _____________ E-Mail: _____________

Important Information: _______________________________________

____

☼ Child Care Provider: ____

Start Date: ______________________________

Contact Person: ____

Address: ____

____

Phone: ___________ Fax: _____________ E-Mail: _____________

Important Information: _______________________________________

____

☼ Child Care Provider: ____

Start Date: ______________________________

Contact Person: ____

Address: ____

____

Phone: ___________ Fax: _____________ E-Mail: _____________

Important Information: _______________________________________

____

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Respite Care

☼ Respite Care Provider: ______________________________

Start Date: ______________________________

Contact Person: ______________________________

Agency: ______________________________

Address: ______________________________

____

Phone: ______________ Fax: ______________ E-Mail: ______________

☼ Respite Care Provider: ______________________________

Start Date: ______________________________

Contact Person: ______________________________

Agency: ______________________________

Address: ______________________________

____

Phone: ______________ Fax: ______________ E-Mail: ______________

☼ Respite Care Provider: ______________________________

Start Date: ______________________________

Contact Person: ______________________________

Agency: ______________________________

Address: ______________________________

____

Phone: ______________ Fax: ______________ E-Mail: ______________

If applicable:

Fiscal Agent: ______________________ Contact: ______________________

Phone: ______________ Fax: ______________ E-Mail: ______________

(Adapted from the Care Notebook with permission, Children's Hospital and Regional Medical Center, Seattle, WA, 2003.)
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Pharmacy

Medical professionals suggest that, if possible, you use one pharmacy for all your prescription medicine needs. In this way, your pharmacist may keep track of all medications being used and any possible problems with interactions between medications. Sometimes, however, you may need to have prescriptions filled at your neighborhood pharmacy and other times your may need to have them filled at the hospital pharmacy. Use this space to keep track of all your pharmacy providers.

☼ Pharmacy: ____
Contact Person: ____
Address: ____
____
Phone: ________________ Fax: ________________ E-Mail: ______________

☼ Pharmacy: ____
Contact Person: ____
Address: ____
____
Phone: ________________ Fax: ________________ E-Mail: ______________

☼ Pharmacy: ____
Contact Person: ____
Address: ____
____
Phone: ________________ Fax: ________________ E-Mail: ______________

Important information for the pharmacist (Such as allergies to medication):
____
____
____

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Special Transportation

☼ Transportation (to and from medical / therapy appointments):

Contact person: ____

Agency: ____

Address: ____

____

Phone: ____________________ Fax: ____________________ E-Mail: ____________________

Important information (such as bus route, rules regarding pick-up, etc.):

____

____

____

____

____

☼ Transportation (to and from medical / therapy appointments):

Contact person: ____

Agency: ____

Address: ____

____

Phone: ____________________ Fax: ____________________ E-Mail: ____________________

Important information (such as bus route, rules regarding pick-up, etc.):

____

____

____

____

____

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Recreation

A number of organizations have programs designed to give children and adults with special needs Recreation opportunities. These include local park and recreation programs. Check with your providers to find out more about recreation opportunities close to your home. Some parents include brochures and activity calendars in this section of their Family Voices of North Dakota Care Notebook.

☼ Recreation Opportunity: ____
Contact Person: ____
Address: ____
Phone: ____________________ Fax: ____________________ E-Mail: __________________
Schedule: ____

☼ Recreation Opportunity: ____
Contact Person: ____
Address: ____
Phone: ____________________ Fax: ____________________ E-Mail: __________________
Schedule: ____

☼ Recreation Opportunity: ____
Contact Person: ____
Address: ____
Phone: ____________________ Fax: ____________________ E-Mail: __________________
Schedule: ____

Notes: ____
____
____
____

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Family Information

☼ Child's Name: ____________________________ Nickname: _____________________________
Date of Birth: ____________________Social Security Number: ___________________________
Diagnosis: ____
Blood Type: ____

Legal Guardian: ____
Address:___________________________________ Phone:______________________________
____

Family Members

☼ Mother's Name: ____
Social Security Number: __________________________________
Address: ____
Daytime Phone: ______________________________Evening Phone: ______________________

☼ Father's Name: ____
Social Security Number: __________________________________
Address: ____
Daytime Phone: ______________________________Evening Phone: ______________________

☼ Sibling's Name: __________________ Age: _____ Name: ____________________ Age: _____
☼ Sibling's Name: __________________ Age: _____ Name: ____________________ Age: _____

☼ Other household members: ____

☼ Important Family Information: ____
____
____

☼ Language spoken at home: ____
Other language(s): ____
Interpreter Needed? Yes: __________ No: __________
Preferred interpreter? Name: ________________________________ Phone: _______________

Emergency Contact

☼ Name: ____
Address: ____
Daytime Phone: ______________________________Evening Phone: ______________________

Family Support Resources

☼ Support Group / Organization: ______________________________
Contact Person: ______________________________
Address/Directions: ______________________________
____
Phone: ______________ Fax: ______________ E-Mail: ______________

☼ Support Group / Organization: ______________________________
Contact Person: ______________________________
Address/Directions: ______________________________
____
Phone: ______________ Fax: ______________ E-Mail: ______________

☼ Religious Organization: ______________________________
Contact Person: ______________________________
Address/Directions: ______________________________
____
Phone: ______________ Fax: ______________ E-Mail: ______________

☼ Counseling Services: ______________________________
Contact Person: ______________________________
Address/Directions: ______________________________
____
Phone: ______________ Fax: ______________ E-Mail: ______________

☼ Department of Human Services: ____________________
Contact Person: ______________________________
Address/Directions: ______________________________
____
Phone: ______________ Fax: ______________ E-Mail: ______________

☼ Other: ______________________________
Contact Person: ______________________________
Address/Directions: ______________________________
____
Phone: ______________ Fax: ______________ E-Mail: ______________

☼ Other: ______________________________
Contact Person: ______________________________
Address/Directions: ______________________________
____
Phone: ______________ Fax: ______________ E-Mail: ______________

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Insurance, Etc.

☼ Primary Insurance Company: ____________________
Policy Number: ____________________
Contact Person / Title: ____________________
Address: ____________________
____
Phone: ____________________ Fax: ____________________

☼ Secondary Insurance Company: ____________________
Policy Number: ____________________
Contact Person / Title: ____________________
Address: ____________________
____
Phone: ____________________ Fax: ____________________

☼ Medicaid (HMO Name if applicable – this is the company name that appears above your child's name and ID Number on the Medicaid Identification Card): ____________________
ID Number: ____________________
Eligibility Worker: ____________________
Office/Location of Eligibility Worker: ____________________
____
Phone: ____________________ Fax: ____________________

☼ Supplemental Security Income (SSI): ____________________
Contact Person / Title: ____________________
Address: ____________________
____
Phone: ____________________ Fax: ____________________

☼ Other: ____________________
Policy Number: ____________________
Contact Person / Title: ____________________
Address: ____________________
____
Phone: ____________________ Fax: ____________________

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Notes

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