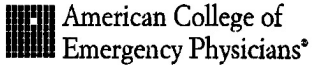


Emergency Information Form for Children With Special Needs

Last name: _____



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. _____	Baseline physical findings:
_____	_____
2. _____	_____
_____	_____
3. _____	Baseline vital signs:
_____	_____
4. _____	_____
_____	_____
Synopsis:	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						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:
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