

Date Completed

Date Revised

Child's Name	Nickname	
DOB	(Relationship)	
Parent (Caregiver)	Address	
Phone #(home)	Blocked? Y <input type="checkbox"/> N <input type="checkbox"/>	Best Time to Reach
E-Mail	Phone	Relationship
Emergency Contact	Phone	Relationship
Health Insurance/Plan	Identification #	

Diagnose(s): Primary:

Secondary:

Secondary:

Emergency Plan Yes Not Applicable

Allergies

Allergies	Reactions:

MEDICATIONS:

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

SPECIALISTS:

PROVIDER	HOSPITAL	Phone

Vital Sign (baselines): Ht Wt Other

Problem List and recommended actions (check all that apply, please explain in space below):

Problem	Recommended Action
<input type="checkbox"/> Behavioral	
<input type="checkbox"/> Communication	
<input type="checkbox"/> Feed & Swallowing	
<input type="checkbox"/> Hearing/Vision	
<input type="checkbox"/> Learning	
<input type="checkbox"/> Orthopedic/Musculoskeletal	
<input type="checkbox"/> Physical Anomalies	
<input type="checkbox"/> Sensory	
<input type="checkbox"/> Stamina/Fatigue	
<input type="checkbox"/> Respiratory	
<input type="checkbox"/> Other	
<input type="checkbox"/> Other	

TO BE AVOIDED:

<input type="checkbox"/> Medical Procedures:
--

<input type="checkbox"/> Activities:
<input type="checkbox"/> Foods:

PRIOR SURGERIES/PROCEDURES:

#1		Date
#2		Date
#3		Date

MOST RECENT LABS/DIAGNOSTICS (AS APPROPRIATE):

TEST	DATE OF PROCEDURE	RESULT	
		Normal	Abnormal
LABWORK (Specify)		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
DRUG LEVELS (Specify)			
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
EEG		<input type="checkbox"/>	<input type="checkbox"/>
EKG		<input type="checkbox"/>	<input type="checkbox"/>
X-Ray		<input type="checkbox"/>	<input type="checkbox"/>
C-Spine		<input type="checkbox"/>	<input type="checkbox"/>
MRI/CT		<input type="checkbox"/>	<input type="checkbox"/>
Other		<input type="checkbox"/>	<input type="checkbox"/>
Other		<input type="checkbox"/>	<input type="checkbox"/>

EQUIPMENT/APPLIANCES/ASSISTIVE TECHNOLOGY:

<input type="checkbox"/> Gastrostomy	<input type="checkbox"/> Adaptive Seating	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Communication Device	<input type="checkbox"/> Orthotics
<input type="checkbox"/> Suctions	Monitors:	<input type="checkbox"/> Crutches
<input type="checkbox"/> Nebulizer	<input type="checkbox"/> Apnea	<input type="checkbox"/> O2
<input type="checkbox"/> Walker	<input type="checkbox"/> Cardiac	<input type="checkbox"/> Glucose
<input type="checkbox"/> Other		

SCHOOL/COMMUNITY INFORMATION:

AGENCY/SCHOOL/CHILD CARE	CONTACT INFORMATION	
	Contact Person:	Phone:
	Contact Person:	Phone:
	Contact Person:	Phone:

FAMILY INFORMATION:

★ SPECIAL CIRCUMSTANCES/COMMENT/FAMILY/YOUTH WANTS US TO KNOW★:

Parent/Caregiver Signature Date

Primary Care Provider Signature Print Name Contact Info Date

Care Coordinator Signature Print Name Contact Info Date