

Emergency Information Form for Children With Special Needs

Last name:



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: Specialty:		Emergency Phone:	
		Fax:	
Current Specialty physician: Specialty:		Emergency Phone:	
		Fax:	
Anticipated Primary ED:		Pharmacy:	
Anticipated Tertiary Care Center:			

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