Emergency Information Form for Children With Special Needs

Am
Em

erican College of Emergency Physicians* American Academy of Pediatrics

Date form completed By Whom

Revised Revised

Initials Initials

Name:	Birth date:	Nickname:			
Home Address:	Home/Work Phone:				
Parent/Guardian:	Emergency Contact Names & Relat	ionship:			
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

Diagnos Medicatio		Proced	lures/Phy	/sical Ex	am contin	iued: Significant bas	eline and	illary find	ings (lab,)	(-ray, ECG)	:
1.											
2.											
3.											
4.				Prostheses/Appliances/Advanced Technology Devices:							
5.											
6.											
Manage	ment Da	ta:									
Allergies: Medications/Foods to be avoided					and why:						
1.											
2.											
3.											
Procedure	s to be avo	bided				and why:					
1.											
2.											
3.											
Immunizations (mm/yy)											
Dates	-					Dates					
DPT						Нер В					
OPV MMR						Varicella 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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