Emergency Information Form for Children with Special Needs

American College of Emergency Physicians	American Academy of Pediatrics	Date Form Completed	/ /	Revised	/ /	Initials	
		By Whom		Revised	/ /	Initials	

Last Name:

Name:		Birth Date:	/ /	Nickname:	
Home Address:		Home/Work Telephone:	( )	( )	
Parent/Guardian:		Emergency Contact Name & Relationship:			
Signature/Consent*:					
Primary Language:		Telephone Number(s):	( )		
			( )		

Physicians:			
Primary Care Physician:		Emergency Telephone:	( )
		Fax:	( )
Current Specialty Physician:		Emergency Telephone:	( )
Specialty:		Fax:	( )
Current Specialty Physician:		Emergency Telephone:	( )
Specialty:		Fax:	( )
Anticipated Primary ED:		Pharmacy:	( )
Anticipated Tertiary Care Center:		Emergency Telephone:	( )

Diagnoses/Past Procedures/Physical Exam:

Diagnoses/Past Procedures	Baseline Physical Findings:
1.	
2.	
3.	
4.	
5.	
Synopsis:	

Baseline Vital Signs:

Temperature:		Pulse:	
BP:	/	Respiratory Rate:	
Pain (1-10):		Blanch Test:	

Baseline Neurological Status:

Motor Problems:	Hemiparesis	Hemiplegia		
Sensory Problems:	Hemianasthesia			
Visual Problems:	Hemianopia	Quandrantanopia		
Attentional Problems:	Neglect	Extinction		
Reflexes:	Pupil Response	Babinski Reflex		
Apraxias:	Ideomotor Apraxia	Ideational Apraxia		
	Limb-kinetic Apraxia	Speech Apraxia		
	Alexia	Dressing	Constructional	Agraphia
Agnosia:	Visual	Tactile	Auditory	
	Anosagnosia	Autopagnosia		

***Consent for release of this form to health care providers**

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Last Name: ______

Diagnoses/Past Procedures/Physical Exam continued:

Medications:	Significant baseline ancillary findings (lab, x-ray, ECG):
1.	
2.	
3.	
4.	
5.	Prostheses/Appliances/Advanced Technology Devices:
6.	
7.	

Management Data:

Allergies: Medications/Foods to be avoided:	Reason to be avoided:
1.	
2.	
3.	
4.	
5.	
Procedures to be avoided:	**Reason to be avoided:**
1.	
2.	
3.	
4.	
5.	

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:**

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