Be Prepared In Case of Emergency

About My Child and Family

Date Created: _____

Person creating document & signature: _____

Child's Name: _____ Child's Nickname: _____

Child's DOB & Age: _____

Child's Gender: _____ Child's Pronouns: _____

Child's Height: _____ Child's Weight: _____

Does the child have any allergies to food, medications, the environment, etc?

_____

Does the child have any special dietary requirements?

_____

Does the child have a favorite snack and/or favorite food? _____

What language does the child speak/understand? _____

Does the child experience any language barriers? _____

Does the child have any favorite hobbies? _____

Parent(s)/Caregiver Name: _____

What the child calls this person(s): _____

Phone Number: _____

Address: _____

Siblings and other people who live in the house with the child: _____

_____

Person beside parent(s)/primary caregiver who knows the child best (friend/relative/nurse):

Name: _____ Phone Number: _____

Who has the authority to make medical decisions if you aren't able to?
(make copies of any legal documentation to keep with this form)

_____

Are there any procedures or life-sustaining treatments that should be avoided - such as intubation, chest/cardiac compressions, etc? *(attach any medical orders with this form)*

_____

My Child's Healthcare Professionals and Medical Team

Physician/Practice That Knows The Child Best

Practice Name: _____

Practice Address: _____

Physician Name: _____

Phone Number: _____

Hospital Contact (specialist): _____

Other agencies that participate in the child's care that may be helpful at this time (early intervention, public health agency, respite services, etc.): _____

Medication and Feeding

Normal Range of Vital Signs for the Child:

Temperature: _____

Blood Pressure: _____

Pulse Ox: _____

Respiratory Rate: _____

Use of Medical Equipment (g-tube, respiratory support, IV access, shunt)?: _____

Daily Medications/Doses/Preparation/Where to find in the home:
(attach a med list and schedule if the following chart is not enough space)

Medication	Dose	Time	Route of Admin

PRN (as needed) Meds and Indication for Each: _____

_____

_____

Pharmacy: _____

Pharmacy Phone: _____

Usual Hospital: _____

Medical Record ID at Hospital: _____

Insurance Company: _____

Insurance ID Numbers: _____

Behavior and Routines

Does the child have predictable symptoms or unpredictable symptoms that others might not understand?

_____

How can one identify these symptoms/behaviors?

_____

How do you address these symptoms/behaviors?

_____

Include copies for existing care plans for symptoms (ie. escalating pain, seizures, respiratory exacerbations).

What is the child's sleep routine?

_____

Is there equipment they use over night (pulse ox, feeding, oxygen, BiPap, etc.)?

_____

What is the child's mobility status?

_____

Is there assistive equipment the child uses for mobility?

_____

Does your family have access to a handicap accessible van? If yes, leave instructions for where to find the key.

_____

Any other transportation services used?

_____

Any other helpful information for a crisis situation? _____

_____