If you need more forms, they are available from the Massachusetts Department of Public Health. Download them from www.mass.gov/dph/fch/directions or call 800-882-1435 (in MA only), 617-624-5070, or 617-624-5992 (TTY).

Information

Important Information about Your Child

1

This chapter has many forms to help you organize and plan your child's care. Use them to write down your child's health care information, medical history, and other important facts. If you write everything down in one place, it will be easy to find when you need it.

Information Forms Checklist

- Parent/Guardian and Emergency Contact Information
- Health Insurance Plan
- Diagnoses
- Allergies
- Emergency Information Form for Children with Special Needs
- All about Me
- Birth and Development: About Mother's Pregnancy
- Birth and Development: About Your Baby
- Family Health History
- Health Care Providers
- Hospitals
- Other Health Care Providers
- Home Health Agency
- School/Day Care Center
- Pharmacies
- Medications
- Event Diary
- Supplies/Equipment
- Hospital Stays
- Important Tests
- Meeting/Appointment Log
- Phone Log
- Important Information for a Sitter

Parent/Guardian and Emergency Contact Information

Child

Name_____ **Nickname** _____
Address _____
Social Security # _____ **Date of Birth** _____
First Language _____
Other Languages Spoken_____

Parent(s)/Guardian(s)

Name_____ **Relationship to Child** _____
Address _____
Telephone: Home _____ **Work** _____ **Cell** _____
First Language _____
Other Languages Spoken_____

Additional Parent(s)/Guardian(s)

Name_____ **Relationship to Child** _____
Address _____
Telephone: Home _____ **Work** _____ **Cell** _____
First Language _____
Other Languages Spoken_____

Does your child have more than one residence? ☐ **Yes** ☐ **No**

If yes, please explain _____

Emergency Contact

Name_____ **Relationship to Child** _____
Address _____
Telephone: Home _____ **Work** _____ **Cell** _____

Child's Name_____ **Date of Birth** _____

Health Insurance Plan

Primary Insurance

Name of Plan _____

Telephone _____

Address_____

Subscriber (Name of Policy Holder) _____

Subscriber ID#_____

Group # _____

Case Manager/Care Coordinator _____

Telephone _____

Other Contacts_____

Telephone _____

Secondary Insurance

Name of Plan _____

Telephone _____

Address_____

Subscriber (Name of Policy Holder) _____

Subscriber ID#_____

Group # _____

Case Manager/Care Coordinator _____

Telephone _____

Other Contacts_____

Telephone _____

Child's Name_____ Date of Birth _____

Diagnoses

Diagnosis Given	Provider who Gave Diagnosis	Date Noted	Notes

Child's Name_____ Date of Birth _____

Allergies

Food	Reaction	Date Noted

Drug	Reaction	Date Noted

Other	Reaction	Date Noted

Emergency Information Form for Children with Special Needs

The following form gives emergency providers the information they need to properly care for your child. Ask your child's primary care provider (PCP) to fill out and sign this form. Give a copy of this form to anyone who may take care of your child in an emergency.

It is very important to **update** the form after any of the following events:

- Important changes in your child's condition or diagnosis
- Any major surgical procedures
- Major changes in medications or dosages
- Changes in health care providers

After updating the form, remember to give new copies to emergency medical services (EMS), your child's providers, and caregivers.

Suggestions on where to keep copies of this form:

- **Health Care Provider's Office:** On file with each of the child's health care providers, including specialists.
- **Home:** At the child's home in a place where it can be easily found, such as on the refrigerator.
- **Car:** In the glove compartment of each parent/guardian's car.
- **Work:** At each parent's workplace.
- **Purse/Wallet:** In each parent's purse or wallet.
- **School:** On file with the child's school, such as in the school nurse's office.
- **Child's Belongings:** With the child's belongings when traveling.
- **Emergency Contact Person:** At the home of the emergency contact person listed on the form.
- **Local EMS:** Give to local ambulance services and hospital emergency departments. Keep more copies on-hand to give to emergency service providers during an emergency situation.

Tip:

Find more information on preparing for emergencies in *Chapter 4.*

Emergency Information Form for Children With Special Needs

Last name:

American College of Emergency Physicians®

American Academy of Pediatrics

Date form completed By Whom	Revised	Initials
	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 .

2.

3.

4.

Synopsis:

Baseline physical findings:

Baseline vital signs:

Baseline neurological status:

*Consent for release of this form to health care providers

All about Me

My name is _____
First Middle Last

My nickname is _____

I live at ☐ Home ☐ School ☐ Foster home

☐ Hospital ☐ Other _____

The names of the people in my family are

First	Last	Relationship to me

Other people who know me well are (friends, babysitter, neighbors)

First	Last	Relationship to me

My Pets

My Pet is a _____ Name of Pet _____

My other pet is a _____ Name of Pet _____

Tip:

This form can help providers learn more about your child. It can also teach your child to describe his or her needs, likes, and dislikes. Give your child as much help as he or she needs in filling it out. Update it as your child grows and changes.

All about Me

Child's Name _____

Date of Birth _____

My "Favorites"

Toys _____

Games _____

Hobbies _____

Songs _____

TV Shows _____

Other _____

Things I like to do during my free time

_____

_____

_____

Foods I like are

_____

_____

_____

Foods I don't like are

_____

_____

_____

I usually go to bed at _____ **o'clock.**

Before bed, I usually _____

_____

_____

_____

Things I need help with are (for example: washing up, brushing teeth, dressing, etc.)

_____

_____

Things I can do myself are _____

_____

_____

Child's Name_____ **Date of Birth** _____

Birth and Development: About Mother's Pregnancy

Please describe any illnesses or problems during pregnancy.

_____

_____

_____

Method of delivery ☐ **Vaginal** ☐ **Caesarian** ☐ **Breech**

Were there problems at delivery? ☐ **No** ☐ **Yes**

If yes, please describe_____

_____

_____

Mother's Obstetrician/Nurse Midwife _____

Telephone _____

Mother's Primary Care Provider _____

Telephone _____

Delivery Setting

Name of Hospital/Birth Center _____

Telephone _____

Address _____

Was child transferred to another hospital? ☐ **No** ☐ **Yes**

If yes, Name of Hospital _____

Telephone _____

Address _____

Child's Name_____ **Date of Birth** _____

Birth and Development: About Your Baby

Birthweight _____**lbs**_____**oz** **Length**_____**inches**

Was baby full-term (37 or more weeks)? ☐ **Yes** ☐ **No** **If no, weeks of gestation**_____

Child's Apgar scores at 1 minute _____ **at 5 minutes** _____

Child's age at first discharge from hospital _____

Baby was fed ☐ **breast milk** ☐ **formula**

If fed formula, list brand _____

Developmental Milestones

My Child	Age:	Notes
Smiled		
Held up head		
Rolled over		
Sat up		
Got first tooth		
Started solid food		
Crawled		
Spoke first word		
Waved "bye bye"		
Walked		
Spoke first sentence		
Toilet trained		
Other:		
Other:		

Tip:

Ask your child's primary care provider (PCP) for information you don't know (such as Apgar scores and growth measurements).

Tip:

Document your child's height and weight on the last page of the ***Massachusetts Lifetime Health and Immunization Record***.

Child's Name_____ **Date of Birth** _____

Family Health History

Is there anyone in the family (parent, brother, sister, grandparents, aunt, uncle, cousin, etc.) with a similar disability or chronic illness? □ **No** □ **Yes**

If yes, who? _____

_____

Does anyone in the family (parent, brother, sister, grandparents, aunt, uncle, cousin, etc.) have:

			If yes, relationship to child
1. Genetic conditions	□ **Yes**	□ **No**	_____
2. Heart problems	□ **Yes**	□ **No**	_____
3. Developmental disability	□ **Yes**	□ **No**	_____
4. Seizure disorder	□ **Yes**	□ **No**	_____
5. Diabetes	□ **Yes**	□ **No**	_____
6. Blood disorder	□ **Yes**	□ **No**	_____
7. Cancer	□ **Yes**	□ **No**	_____
8. Vision and/or hearing impairment	□ **Yes**	□ **No**	_____
9. Metabolic or nutritional disorder	□ **Yes**	□ **No**	_____
10. Other _____	□ **Yes**	□ **No**	_____

Has anyone in the family had genetic testing or counseling?

□ **Yes** □ **No** □ **Don't Know**

If yes, please describe _____

_____

Is there any other family health information that might be related to your child's special health needs? _____

_____

_____

_____

Child's Name_____ **Date of Birth** _____

Health Care Providers

Tip: Instead of filling out the form, staple your provider's business card onto the space provided.

Primary Care Provider

Name_____ **Specialty (if any)**_____

Clinic/Hospital Name _____ **Telephone** _____

Address_____

Fax _____ **Email** _____

Medical Specialists and Health Care Providers

Name _____

Specialty_____

Address _____

Telephone _____

Fax _____

Email _____

Clinic/Hospital Name _____

Frequency of Visits (how often) _____

Name _____

Specialty_____

Address_____

Telephone _____

Fax _____

Email _____

Clinic/Hospital Name_____

Frequency of Visits (how often) _____

Name _____

Specialty_____

Address _____

Telephone _____

Fax _____

Email _____

Clinic/Hospital Name _____

Frequency of Visits (how often) _____

Name _____

Specialty_____

Address_____

Telephone _____

Fax _____

Email _____

Clinic/Hospital Name_____

Frequency of Visits (how often) _____

Child's Name ______________________ **Date of Birth** ______________

Health Care Providers

Name ______________________
Specialty ______________________
Address ______________________
Telephone ______________________
Fax ______________________
Email ______________________
Clinic/Hospital Name ______________________
Frequency of Visits (how often) ______________

Name ______________________
Specialty ______________________
Address ______________________
Telephone ______________________
Fax ______________________
Email ______________________
Clinic/Hospital Name ______________________
Frequency of Visits (how often) ______________

Name ______________________
Specialty ______________________
Address ______________________
Telephone ______________________
Fax ______________________
Email ______________________
Clinic/Hospital Name ______________________
Frequency of Visits (how often) ______________

Name ______________________
Specialty ______________________
Address ______________________
Telephone ______________________
Fax ______________________
Email ______________________
Clinic/Hospital Name ______________________
Frequency of Visits (how often) ______________

Name ______________________
Specialty ______________________
Address ______________________
Telephone ______________________
Fax ______________________
Email ______________________
Clinic/Hospital Name ______________________
Frequency of Visits (how often) ______________

Name ______________________
Specialty ______________________
Address ______________________
Telephone ______________________
Fax ______________________
Email ______________________
Clinic/Hospital Name ______________________
Frequency of Visits (how often) ______________

Child's Name_____ Date of Birth _____

Hospitals

Main Hospital

Name of Hospital_____

Address_____

Medical Record #_____

Hospital Operator Telephone _____

Emergency Department Telephone _____

Contact Person Name _____ Title_____

Telephone _____ Fax _____

Email _____

Other Hospital

Name of Hospital_____

Address_____

Medical Record #_____

Hospital Operator Telephone _____

Emergency Department Telephone _____

Contact Person Name _____ Title_____

Telephone _____ Fax _____

Email _____

Child's Name_____ **Date of Birth** _____

Other Health Care Providers

Use this form to list service providers such as therapists, counselors, Early Intervention providers, care coordinators or case managers, personal care attendants (PCAs), respite providers, state agency contacts, etc.

Service(s)_____

Agency Name _____

Address_____

Contact Person _____ **Telephone** _____

Fax _____ **Email** _____

Frequency of Visits (how often)_____

Service(s)_____

Agency Name _____

Address_____

Contact Person _____ **Telephone** _____

Fax _____ **Email** _____

Frequency of Visits (how often)_____

Service(s)_____

Agency Name _____

Address_____

Contact Person _____ **Telephone** _____

Fax _____ **Email** _____

Frequency of Visits (how often)_____

Child's Name_____ Date of Birth _____

Other Health Care Providers

Service(s)_____

Agency Name _____

Address_____

Contact Person _____ Telephone _____

Fax _____ Email _____

Frequency of Visits (how often)_____

Service(s)_____

Agency Name _____

Address_____

Contact Person _____ Telephone _____

Fax _____ Email _____

Frequency of Visits (how often)_____

Service(s)_____

Agency Name _____

Address_____

Contact Person _____ Telephone _____

Fax _____ Email _____

Frequency of Visits (how often)_____

Service(s)_____

Agency Name _____

Address_____

Contact Person _____ Telephone _____

Fax _____ Email _____

Frequency of Visits (how often)_____

Child's Name_____ **Date of Birth** _____

Home Health Agency

Agency Name _____

Contact Person _____ **Telephone** _____

Address_____

Fax _____ **Email** _____

Service(s) to be provided (for example, nursing, therapy, home health aides, etc)

Service	Frequency (how often)	Amount (hours per visit)
	visits/week	hours/visit
	visits/week	hours/visit
	visits/week	hours/visit
	visits/week	hours/visit
	visits/week	hours/visit

Notes/Comments

_____

_____

_____

_____

_____

_____

_____

_____

Child's Name_____ Date of Birth _____

School/Day Care Center

Name of School _____

Address _____

Principal_____Telephone _____

School Nurse_____ Telephone _____

Teacher(s) _____ Telephone _____

Aide(s) _____

Special Education Contacts_____ Telephone _____

_____

Therapist(s)_____ Telephone _____

_____

School Psychologist_____ Telephone _____

Guidance Counselor_____ Telephone _____

Parent Advisory Committee (PAC) Contact
_____ Telephone _____

MASSTART Contact_____ Telephone _____

Is there a school-based health center at your child's school? ☐ Yes ☐ No

If yes, Name of Center_____ Telephone _____

School Transportation

Agency Name_____

Contact Name _____ Telephone _____

Address _____

Child's Name_____ Date of Birth _____

Pharmacies

Main Pharmacy

Name_____

Address_____

Telephone_____

Fax_____

Hours of Business_____

Contact Person_____

Other Pharmacy

Name_____

Address_____

Telephone_____

Fax_____

Hours of Business_____

Contact Person_____

Child's Name_____ **Date of Birth** _____

Medications

Use this form to keep track of all medications your child takes. Include vitamins, over-the-counter medicines, and dietary supplements in the list. When medications or doses are changed, do not erase or black out the old information. Instead, draw a line through it and make a new entry to the list. (See below for example.) This way you have a complete record.

Medication Name	Dosage (How much/how often? Special instructions?)	Reason for Taking drug	Start Date	End Date	Prescribing Doctor	Notes
[EXAMPLE] ~~Ritalin~~	~~5 mg 2x day (give at breakfast & lunch)~~	~~ADHD~~	~~3/15/03~~	~~3/31/03~~	~~Goldberg~~	~~Takes lunch dose at school~~
[EXAMPLE] Ritalin	10 mg 2x day (give at breakfast & lunch)	ADHD	4/01/03		Goldberg	Takes lunch dose at school

Child's Name_____ **Date of Birth** _____

Medications

Medication Name	Dosage (How much/how often? Special instructions?)	Reason for Taking drug	Start Date	End Date	Prescribing Doctor	Notes

Child's Name_____ **Date of Birth** _____

Event Diary

Use this sheet to keep track of important events related to your child's health that may happen from time to time. Some examples include seizures, oxygen requirements, frequency of suctioning, vomiting.

Date	Activity/Information

Child's Name____________________ **Date of Birth** ____________________

Supplies/Equipment

Description of Item

Provider/Vendor Name

Contact Person **Telephone**

Prescribed by **Telephone**

Reason Prescribed

Contact Person for Service/Insurance Approval

Telephone

Comments (for example: kinds of service needed, part numbers, costs)

Description of Item

Provider/Vendor Name

Contact Person **Telephone**

Prescribed by **Telephone**

Reason Prescribed

Contact Person for Service/Insurance Approval

Telephone

Comments (for example: kinds of service needed, part numbers, costs)

Description of Item

Provider/Vendor Name

Contact Person **Telephone**

Prescribed by **Telephone**

Reason Prescribed

Contact Person for Service/Insurance Approval

Telephone

Comments (for example: kinds of service needed, part numbers, costs)

Child's Name ______________________ **Date of Birth** ______________

Supplies/Equipment

Description of Item ______________________

Provider/Vendor Name ______________________

Contact Person ______________________ **Telephone** ______________

Prescribed by ______________________ **Telephone** ______________

Reason Prescribed ______________________

____

Contact Person for Service/Insurance Approval ______________________

______________________ **Telephone** ______________

Comments (for example: kinds of service needed, part numbers, costs) ______________________

____

Description of Item ______________________

Provider/Vendor Name ______________________

Contact Person ______________________ **Telephone** ______________

Prescribed by ______________________ **Telephone** ______________

Reason Prescribed ______________________

____

Contact Person for Service/Insurance Approval ______________________

______________________ **Telephone** ______________

Comments (for example: kinds of service needed, part numbers, costs) ______________________

____

Description of Item ______________________

Provider/Vendor Name ______________________

Contact Person ______________________ **Telephone** ______________

Prescribed by ______________________ **Telephone** ______________

Reason Prescribed ______________________

____

Contact Person for Service/Insurance Approval ______________________

______________________ **Telephone** ______________

Comments (for example: kinds of service needed, part numbers, costs) ______________________

____

Child's Name_____ **Date of Birth** _____

Hospital Stays

Date of Admission _____ **Date of Discharge**_____

Name of Hospital _____ **Telephone** _____

Address_____

Doctor(s)/Surgeon(s)_____

Reason for Admission_____

_____

Outcome_____

_____

Date of Admission _____ **Date of Discharge**_____

Name of Hospital _____ **Telephone** _____

Address_____

Doctor(s)/Surgeon(s)_____

Reason for Admission_____

_____

Outcome_____

_____

Date of Admission _____ **Date of Discharge**_____

Name of Hospital _____ **Telephone** _____

Address_____

Doctor(s)/Surgeon(s)_____

Reason for Admission_____

_____

Outcome_____

_____

Child's Name_____ **Date of Birth** _____

Hospital Stays

Date of Admission _____ **Date of Discharge**_____

Name of Hospital _____ **Telephone** _____

Address_____

Doctor(s)/Surgeon(s)_____

Reason for Admission_____

_____

Outcome_____

_____

Date of Admission _____ **Date of Discharge**_____

Name of Hospital _____ **Telephone** _____

Address_____

Doctor(s)/Surgeon(s)_____

Reason for Admission_____

_____

Outcome_____

_____

Date of Admission _____ **Date of Discharge**_____

Name of Hospital _____ **Telephone** _____

Address_____

Doctor(s)/Surgeon(s)_____

Reason for Admission_____

_____

Outcome_____

_____

Child's Name____________________ **Date of Birth** ____________________

Important Tests

☐ **Blood** ☐ **X-ray** ☐ **CT** ☐ **MRI** ☐ **Other** ____________________ **Date Performed** ____________________

Description____________________

Doctor who Ordered Test____________________ **Telephone** ____________________

Results____________________

Location of Test Record____________________ **Telephone** ____________________

Comments____________________

☐ **Blood** ☐ **X-ray** ☐ **CT** ☐ **MRI** ☐ **Other** ____________________ **Date Performed** ____________________

Description____________________

Doctor who Ordered Test____________________ **Telephone** ____________________

Results____________________

Location of Test Record____________________ **Telephone** ____________________

Comments____________________

☐ **Blood** ☐ **X-ray** ☐ **CT** ☐ **MRI** ☐ **Other** ____________________ **Date Performed** ____________________

Description____________________

Doctor who Ordered Test____________________ **Telephone** ____________________

Results____________________

Location of Test Record____________________ **Telephone** ____________________

Comments____________________

Child's Name________________________________ Date of Birth ____________________

Important Tests

☐ Blood ☐ X-ray ☐ CT ☐ MRI ☐ Other ________________ Date Performed ____________

Description____

Doctor who Ordered Test__________________________ Telephone ______________________

Results____

____

Location of Test Record___________________________ Telephone ______________________

Comments____

____

☐ Blood ☐ X-ray ☐ CT ☐ MRI ☐ Other ________________ Date Performed ____________

Description____

Doctor who Ordered Test__________________________ Telephone ______________________

Results____

____

Location of Test Record___________________________ Telephone ______________________

Comments____

____

☐ Blood ☐ X-ray ☐ CT ☐ MRI ☐ Other ________________ Date Performed ____________

Description____

Doctor who Ordered Test__________________________ Telephone ______________________

Results____

____

Location of Test Record___________________________ Telephone ______________________

Comments____

____

Child's Name_____ **Date of Birth** _____

Meeting/Appointment Log

Use this form to keep track of meetings and appointments you have about your child's health care.

Date and Time of Meeting	Name of Person and Agency	Contact Information	Notes (what was discussed or decided)

Child's Name_____ **Date of Birth** _____

Phone Log

It is easy to lose track of what you discussed with providers when you have so many different phone calls about your child. Use this form to keep track of phone calls and other conversations you have about your child's health care.

Date and Time of Conversation	Name of Person and Agency	Phone Number	Notes (what was discussed or decided)

Important Information for a Sitter

Parent(s)/Guardian(s) Name(s)_____

I/We will be at _____ **I/We will be home around**_____

Telephone _____ **Cell Phone** _____ **Pager** _____

Special instructions _____

_____

_____

Significant events during past 48 hours_____

_____

_____

Medications to be given and time(s)_____

_____

_____

In Case of an Emergency: CALL 911

Child's Name_____

Home Telephone _____ **Date of Birth**_____

Address_____

Doctor's Name _____ **Telephone** _____

Other person to call in case of an emergency (i.e. relative, neighbor, friend)_____

_____

Allergies_____

Extra equipment/supplies are located_____

Fuse box or breaker is located_____

Fire extinguisher is located_____

Flashlight is located_____

Fill out a new form and give it to your child's sitter each time.
More forms are available from the Massachusetts Department of Public Health. Download them from www.mass.gov/dph/fch/directions or call 800-882-1435 (in MA only) or 617-624-5070.