

Emergency Information Form for Children With Special Needs

 American College of
Emergency Physicians*

American Academy
of Pediatrics 
DEDICATED TO THE HEALTH OF ALL CHILDREN

Date Form
Completed
By Whom

Revised
Revised

Initials
Initials

Name:		Birth Date:	Nickname:
Home Address:		Home/Work Phone:	
Parent/Guardian:	Emergency Contact Names and 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:
2.	
3.	Baseline Vital Signs:
4.	
Synopsis:	Baseline Neurological Status:

*Consent for release of this form to health care providers

Diagnosis/Past Procedures/Physical Exam continued:

Medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Significant Baseline Ancillary Findings (lab, x-ray, ECG):

Prostheses/Appliances/Advanced Technology Devices:

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: