

## Information Sheet

Child's Name: \_\_\_\_\_

Date of Plan: \_\_\_\_\_  
*(review annually)*

Birthdate: \_\_\_\_\_

Guardian(s) Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_

Phone: \_\_\_\_\_

Diagnoses: \_\_\_\_\_

\_\_\_\_\_



My child is \_\_\_\_\_ years old and seems like a child who is \_\_\_\_\_.

### Medications

| Name | Indication | Dosing Schedule | Notes |
|------|------------|-----------------|-------|
|      |            |                 |       |
|      |            |                 |       |
|      |            |                 |       |
|      |            |                 |       |
|      |            |                 |       |

### Allergies

Food: \_\_\_\_\_

Medication: \_\_\_\_\_

Other: \_\_\_\_\_

### Supportive equipment

- Wheelchair
- Crutches
- Eyeglasses
- Hearing aids
- ID tag
- Feeding tube
- Vent dependent
- Other: \_\_\_\_\_

**My child communicates:**

- In full sentences and speaks clearly
- In full sentences, but it may be hard to understand him/her at times
- In short phrases or single words
- Using an electronic communication device
- With pictures
- With sign language or gestures

**My child understands:**

- Most verbal directions
- Most verbal directions, but may need to have one direction presented at a time
- My child needs directions presented in brief, 2-3 word phrases
- My child responds to his/her name

My child understands the following directions verbally:

- No
- Come here
- Stop

My child does not understand verbal words, but may understand if:

- Presented in sign language
- Given with a gesture
- With pictures or a communication device

Below are a list of some of my child's likes and dislikes. These may help you better understand my child, and help you when you are interacting with my child.

My child likes: \_\_\_\_\_

My child does not like:

- Loud noises
- Physical touch
- Bright lights
- Animals: \_\_\_\_\_
- Other: \_\_\_\_\_

- My child may become aggressive when upset.
- My child may attempt to run away when approached by a stranger.

**Experience with medical providers**

- Very familiar with medical providers and comfortable with doctors
- Very familiar with medical providers, but dislikes the doctor
- Limited experience with medical providers outside of primary care
- History of difficulty with medical procedures (e.g., blood pressure)

An emergency bag is located: \_\_\_\_\_

**Items included:**

- |  |                                   |
|--|-----------------------------------|
| <input type="checkbox"/> First aid kit   | <input type="checkbox"/> Blankets |
| <input type="checkbox"/> Information sheet   | <input type="checkbox"/> Toys     |
| <input type="checkbox"/> Written phone numbers of emergency contacts (other relatives) | <input type="checkbox"/> _____    |
| <input type="checkbox"/> Medications   | <input type="checkbox"/> _____    |
| <input type="checkbox"/> Changes of clothes  | <input type="checkbox"/> _____    |
| <input type="checkbox"/> Hygiene items   | <input type="checkbox"/> _____    |