Medical Information Form

Child's Name: first name, last name _____

Date of Birth: month, day, year _____

Health Insurance information

- Insurance group number, policy number, contact information: _____
- Insurance group number, policy number, contact information: _____
- Medicaid number, contact information: _____

Medical Conditions: List your child's diagnoses or conditions. List warning signs that the condition may be getting worse.

_____

_____

_____

Asthma, Allergies, Sensitivities and Sensory Issues:

My child has environmental, food, medicine, or other allergies or sensitivities.

- ☐ My child cannot stand too much heat or cold.
- ☐ My child is sensitive to the sun.
- ☐ My child has a weak immune system. He or she needs to keep away from others. He or she gets sick easily.
- ☐ My child has asthma or reactive airway disease.
- ☐ My child has **life threatening** allergies. Describe: _____
- ☐ My child _____has had _____has not had an anaphylactic reaction. Describe: _____
- ☐ My child has **non-life-threatening** allergies. Describe: _____
- ☐ My child takes medicine for his or her allergies. See the medicine list below.
- ☐ My child is sensitive to chemicals. Describe: _____
- ☐ My child has sensory issues:
  - My child does not like to be touched.
  - My child does not like some textures: _____
  - My child does not like some noises: _____
  - My child has other sensory issues: _____

Medicine and Special Formulas: List prescription and over the counter medicines, vitamins, supplements and special formulas.

- My child ___can ____cannot miss a dose of medicine or special formula: _____
  _____
- My child needs medicine ___ once a day ___several times a day.
- Pharmacy name, city, state, phone and email: _____
  _____

Medicine Name Mark with * if can't skip	**Dose (How Much)**	**Times Taken**	**How Taken (such as by mouth, shot, other)**	**Why Taken**	**P, OTC, O****	**Care, equipment, materials needed (examples include refrigeration, oral syringe, tubing, bandages, adapted spoon)**

**P=Prescription medicine OTC=Over the Counter medicine O=Other medicine
* Medicine that can't be skipped

Medical Devices, Supplies, Adapted Equipment and Assistive Technology

Equipment and Supplies	Used For	Manufacturer and Model Number	Vendor Name Vendor Address, Phone Number and Email Comments (include information about batteries and electricity)

Other Information about battery, electricity or other needs:

Basic instructions for most important equipment:

Necessary Tests or Treatments

Test or treatment child has on a regular basis that must continue in an emergency	How often	How long child can go without treatment	Where child receives treatment; other comments

***If your child receives dialysis or other life-sustaining treatment, think about knowing more than one place to receive the treatment.**

Vaccines

Mark the vaccines that your child has had. Leave blank any you don't remember and check with your child's primary care doctor.

My Child's Vaccines:

For children from birth to age 6:	**For children and youth ages 7-18:**
_____Hepatitis B.	_____Tetanus, Diptheria, Pertussis (Whooping Cough). Also known as Tdap.
_____Rotavirus.	_____Human Papillomavirus also known as HPV.
_____Diptheria, Tetanus, Pertussis (Whooping Cough). Also known as the DPT or DTaP.	_____Meningococcal, also known as Meningitis or MCV.
_____Haemophilus influenza type b. Also known as the Hib.	_____Influenza, also known as flu shot.
_____Pneumococcal also known as pneumonia.	_____Pneumococcal, also known as pneumonia.
_____Inactivated poliovirus also known as polio or IPV.	_____Hepatitis A.
_____Influenza, also known as flu shot.	_____Hepatitis B.
_____Measles, Mumps, Rubella also known as MMR.	_____Inactivated Poliovirus, also known as polio or IPV.
_____Varicella, also known as chicken pox.	_____Measles, Mumps, Rubella also known as MMR.
_____Hepatitis A.	_____Varicella also known as chicken pox.
_____Meningococcal, also known as Meningitis.	

Explanations (for example the reason your child did not have a certain vaccine)

_____

_____

_____

_____

_____

_____

Doctors, Dentists, Therapists, Hospitals, Home Health Agencies

Put a 1, 2, or 3 next to the names of the doctors you want called first, second and third.

Doctors (primary and specialists)	Specialty (for primary care provider write in "primary")	Contact Information
Dentist:		
Hospital:		
Home Health Agency:		

Important Past Illness and Medical Condition History (Past illness, surgery and anesthesia complications. Important baseline findings and key test results. Include dates.)

- **AVOID** these medical procedures:

  _____

  _____

  _____

- Past illnesses and hospital stays (and dates):

  _____

  _____

  _____

- Past surgeries and anesthesia complications (and dates):

  _____

  _____

  _____

- Key baseline findings and test results (and dates):

  _____

  _____

  _____