Be Prepared In Case of Emergency

(if you need to hand your child's care over to another person)

About My Child & Family

Date created:

Person creating document and signature_____

Child's Name_____ Nickname_____

Child's DOB:_____

Height: _____ Weight: _____

Diagnosis:_____

Best way to communicate with your child: ie., talk, touch, IPad, look into eyes

What calms your child?

What frightens your child or causes them anxiety?

Does your child have "security" objects? (blanket, favorite toy, shows on Ipad, music)

Parent(s)/Caregiver name_____

What your child calls this person(s)_____

Phone Number: _____

Address: _____

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

_____

Person beside parent(s)/primary caregiver who knows child the 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. If there are medical orders (MOLST, POLST) attach them with this form.

_____

My Child's Providers and Medical Team

Physician/practice that knows child the best

Practice Name and Address: _____

Physician Name: _____

Phone Number: _____

Hospital contact (specialist): _____

Other agencies that participate in your child's care that may be helpful at this time.
(early Intervention, Public Health agency, block nursing agency, respite services. etc.)

Medication & Feeding

Normal range of Vital Signs for your child -

Temperature:_____

Blood Pressure:_____

Pulse Ox: _____

Respiratory Rate: _____

Use of medical equipment? (g-tube, respiratory support, IV access, shunt) _____

Daily Meds/doses/preparation/where to find in the home?
(attach full med list and schedule if the following chart is not enough space)

MED	DOSE	TIME

PRN (as needed) Meds and indication for each: _____

Pharmacy: _____ phone: _____

Usual Hospital: _____

Medical Record ID at that Hospital: _____ phone:_____

Insurance company and ID numbers: _____

Behavior and Routines

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

How can one identify these symptoms/behaviors?

How do you address these symptoms/behaviors?

Copies of existing care plans for symptoms ie. Escalating Pain, Seizures, Respiratory exacerbations

What is your child's sleep routine?

Is there equipment they use overnight? (pulse ox, feeding, oxygen, BiPap etc)

What is your child's mobility status?

Is there assistive equipment your child uses for mobility?

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

Are any other transportation services used? Please list.

Any other helpful information for a crisis situation?

Additional Resources for Future Use when NOT in an Emergency

Care Notebook from the American Academy of Pediatrics National Resource Center: https://medicalhomeinfo.aap.org/tools-resources/Pages/For-Families.aspx

The Respite Care Notebook from the Child Neurology Foundation: https://www.childneurologyfoundation.org/programs/respite-care/

Care Plan Book from the Pediatric Palliative Care Coalition: https://ppcc-pa.org/toolkits/care-plan-book/