Swindells Resource Center of Providence Child Center

Providing support for families of children with special needs

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Swindells Resource Center

This *Care Notebook* is free to all families of children who experience disability or special needs in Oregon or Southwest Washington. It is intended to help families organize the many pieces of their child's life in the simplest manner possible. Whether your child has a medical, developmental or mental health diagnosis, you are in charge of the information you need to have with you when at appointments.

The Swindells Center staff searched national, regional, and local resources for the best information and with the careful guidance of parents and providers, developed these pages to make it easier to share information with educators, therapists and family.
We appreciate the parents, grandparents, family members and foster parents who shared their perspectives, knowledge, and experiences during this project.

Care notebook trainings:
We welcome the opportunity to help you tackle all that paperwork. Please call to make an appointment for our next training. Bring in those boxes and bags of information and paperwork and we are happy to help you organize it.

How do I get a notebook?
Families may receive one *Care Notebook* per child with special needs at no cost. Families should call or email the Swindells Center to make their request.

The Swindells Center:
503.215.2429
833.868.4769
Swindells@providence.org

The *Care Notebook* can make life a little easier!

Set up the notebook:

This notebook was developed to help families of children who experience disability or special health care needs track the many important pieces of information regarding their care and day-to-day needs.

As you care for your child, you get paperwork, forms, letters and other items that you may not know where to keep or how to use. The notebook can help you keep and share information with your family members, as well as your child's education and healthcare team.

Use your notebook to:

- Share your child's routine, preferences, and needs with your family members, child care providers and friends.
- Retain your child's health history and records.
- Track changes in your child's medicines or treatments.
- Keep evaluations and appointment schedules in one easy spot.
- Have your family medical history ready.
- List phone numbers of health care providers and other community support agencies

Consider these helpful hints when using the notebook:

Keep this notebook where it is easy to find, taking it with you to all doctor, therapy and school appointments.

Add new information whenever there is a change in your child's daily routine, schedule or treatment. Medical offices can copy evaluation reports, immunization records, and specialist reports and give them to you to insert into the notebook.

PROVIDENCE Child Center

Gather the paperwork and information you have about your child. This could include prescription slips, medical records, summary of hospital stays, child's school reports, dietary needs and medication.

Look through the notebook:

Which of these pages could help you keep track of information about your child's health or care?

Chose the pages you like. Make this Notebook work for you! Contact us for replacement pages!

Decide which information is most important to keep in the notebook:

What information do you look up often?

What information might those who care for your child need?

Put your notebook together.

- Personalize the cover by using your child's photo or artwork. Make it your own!
- Everyone has different ways of organizing information. The only important thing is that you make it easy

for YOU to locate the information you need.

- Tabbed dividers: Create your own sections.
- Pocket dividers: Store reports and loose materials.
- Plastic pages: Store business cards, insurance cards and photographs.

Swindells Resource Center

A Parent's Perspective

I appreciate it when you:

Remember that it is normal and healthy to feel anger and denial sometimes when I grieve my child's extra challenges.

Realize that I am struggling to regain my balance in a confusing and challenging situation.

Recognize that my child's health needs don't erase the other real life challenges all families face: bills, job stressors, plumbing issues and not enough time in any day.

Listen when I say is something wrong. I know my child. Help me solve the puzzle until we both understand what is going on. Telling me my child will outgrow it only frustrates me and it could be harmful to my child.

Help me to be a competent partner in healthcare. I have to be. My child relies on me for everything.

Help me find the information I need to understand my child's condition. Send me to resource centers or other providers if you need to. Tell me what books and articles are the good ones. The more I know about my child, the more I can enjoy and work with my child.

Realize you can't tell me too much about my child's condition. I may not absorb it all at once, so you may have to repeat yourself.

Help me enjoy the smallest successes and recognize my child's limitations for what they are.

Keep me informed about everything, even referrals. Call me, send me a note, and let me know that my child has not been forgotten or lost in a tangle of procedural tape.

See my whole child, not just the diagnosis.

Work with the other professionals who are involved in my child's care. We each hold only one piece of the puzzle.

I don't think these are too much to ask for. Do you?

Created by: Swindells Family Advisory Board, 2007

HEALTH INFORMATION

This section provides information that you or another caregiver might need in providing medical care for your child. Information includes:

- Medical and health summary
- Emergency contact information
- Medical power of attorney
- Information regarding changes to treatment plan
- Personal and family medical history
- Insurance information
- Appointment log
- Information regarding medications, past and present
- Hospital and surgical care
- Lists of care providers and specialists
- List of specialized equipments and vendors
- Summaries of specific care needs
- Dental care information and log
- Behavioral health care information and log

IN CASE OF AN EMERGENCY:

Child's Name:_____ Nickname: _____

Child's Date of Birth:_____ Child's SSN:_____

Primary Language/Communication Means:_____

Parent/Guardian Names:_____

Relationship to Child:_____

Home Address:_____

Emergency Contact Numbers:_____ _____ _____
(cell) (home) (work)

Name of School:_____ Phone:_____

Personal Descriptors:

Gender:_____

Height:_____ Weight: _____ (Photo Here)

Hair Color: _____ Eye color:_____

Scars or birthmarks: _____

Glasses: *Yes* *No* Hearing Aids: *Yes* *No*

Primary Diagnosis:_____

Co-existing diagnosis: _____

Medications	**Dose**	**Time:**
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

Allergies:_____

Emergency Contacts

Name and relationship:_____

Address:_____

Phone:_____Work : _____Cell:_____

Primary Care Physician:_____Phone:_____

Specialist:_____ Phone:_____

Specialist:_____ Phone:_____

Additional Information to know about my child in an emergency (sensitivities, seizures, previous events – on reverse):

MEDICAL POWER OF ATTORNEY:

I, _____do give permission

(Name of Parent or Guardian)

for the following people to make decisions regarding medical treatment for my child, _____, should the need arise.

(Child's Name)

Power of Attorney is given for emergency medical and dental care, including anesthesia when it is needed. This consent is effective from this date and remains active until the date indicated here, unless otherwise revoked:

_____.

Date

Name:

Address:_____

Phone:_____

Cell:_____

Name:

Address:_____

Phone:_____

Cell:_____

Name:

Address:_____

Phone:_____

Cell:_____

NOTARY

Parent name:

Parent signature:

seal here

Date:

Notary name:

Notary signature:

Date:

MY CHILD'S INFORMATION AND HEALTH SUMMARY

PERSONAL INFORMATION:

Name:_____Nickname:_____

Date of Birth:_____Social Security Number:_____Blood Type:_____

Primary Diagnosis:_____

_____

Insurance Company: _____ ID#_____ Group#_____

Primary Language Spoken at home:_____

Other language familiar to child:_____ Interpreter Needed: ☐ Yes ☐ No

Parent(s)/Legal Guardian(s):_____

Address:_____

Phone:_____Cell:_____Email:_____

SPECIAL CARE NEEDS:

Allergies: _____

Special Safety Instructions/Crisis Plan:_____

_____

Challenges with movement, hearing, eyesight, thinking:_____

Special Equipment, treatment challenges, unusual findings:_____

_____

FAMILY INFORMATION:

Siblings Name:_____Age: _____ Name:_____ Age:____
Name:_____Age: _____ Name:_____Age:____

Other Household Members:_____

Emergency Contact:

Name:_____ Relationship to Child:_____
Address:_____
Phone:_____Cell:_____Email:_____

KEEPING MY CHILD'S TEAM UP TO DATE

DATE:

TO: _____FROM:_____

RE: _____ DATE OF BIRTH:_____

(child's name)

This note is to keep you informed of a change in treatment for my child. The following action has been taken by: _____.

(Professional's name and title)

They provide the following service for my child:_____

And can be reached at the following phone number and address:_____

_____

☐ Medication Change

Dosage Change: from_____ to_____

Type of Medication: from_____ to_____

☐ Change to Treatment Plan_____

_____

☐ Change to IEP_____

Report, lab test result (copies) or other paperwork are attached and include:_____

_____

Any other important changes in my child's life:_____

_____

Please include this information in my child's records. I can be reached at:_____

at the following times:_____. _____

SUMMARY OF CARE
MEDICAL HISTORY

Birth History Unknown ☐
Child's Name: _____Date of Birth:_____

Pregnancy/Birth History
Smoker: ☐ Yes ☐ No Amount:_____
Alcohol use during pregnancy: ☐ Yes ☐ No Amount:_____
Drug use during pregnancy: ☐ Yes ☐ No Type/Amount:_____

Complications or illnesses during pregnancy or at birth (jaundice, prematurity)?_____

_____

Child's Weight at Birth ____lbs ____oz. APGAR Score_____ Length_____ inches

Child's Blood Type_____ Date of Last Physical Exam:_____

Immunizations:											
Dates:						Dates:					
DTaP						HEP A					
Polio						HEP B					
MMR						Rotovirus					
HiB						PCV					
Varicella						Td					
PPD/Mantoux						HPV					

Does your child have a history of any of the following?

Additional Info/Date:	*Additional Info/Date:*
☐ Colds	☐ Cleft Palate
☐ Respiratory Infections	☐ Developmental Delay
☐ Influenza	☐ Seizures
☐ Sinusitis	☐ Hearing Impairments
☐ Ear Infections	☐ Constipation/Diarrhea
☐ High Fever	☐ Head Injury
☐ Vision Problems	☐ Coma
☐ Tonsillitis	☐ Metabolic Disorder
☐ Bronchitis	☐ Failure to thrive
☐ Asthma	☐ Anemia
☐ Chicken Pox	☐ Pneumonia
☐ Heart Problems	☐ Reflux
☐ Other:	☐ Other:

☐ Allergies Please list: What Happens:	☐ Genetic Syndrome Please specify:
☐ Fractures Please specify:	☐ Surgery Please specify:

SUMMARY OF CARE
FAMILY HEALTH HISTORY

Family History Unknown ☐

Problem	Relation (parent, sibling, grandparent, etc.)	Age when diagnosed
Alcohol/ Drug Abuse		
Allergies		
Heart Conditions		
Down Syndrome		
Arthritis		
Vascular Disorders		
Feeding		
Stomach/Bowel		
Hearing Loss		
Intellectual Disability		
Developmental Delay		
Mental Illness		
Emotional/Behavioral		
Breathing Problems		
Asthma		
Seizures		
Speech & Language		
Kidney and Bladder		
Eyes/Vision		
Diabetes		
Autism Spectrum		
Genetic Disorder		
Stroke		
Cancer		
Other		

Other comments or helpful information:

SUMMARY OF CARE
INSURANCE INFORMATION

Insurance Company:_____

Policy/ID Number:_____ Group Number:_____
Contact Person/Title: _____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Insurance Company:_____

Policy/ID Number:_____Group Number:_____
Contact Person/Title: _____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Insurance Company:_____

Policy/ID Number:_____ Group Number:_____
Contact Person/Title: _____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Supplemental Security Income (SSI):
Contact Person/Title: _____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Other:
Contact Person/Title: _____
Address:_____
Phone:_____ Fax:_____Email:_____
Website:_____

SUMMARY OF CARE
APPOINTMENT LOG: MEDICAL/SURGERY

Date	Height / Weight	Provider	Procedure/ Reason for Visit	Results	Follow up

SUMMARY OF CARE
HOSPITAL AND FOLLOW UP CARE

Investigate your child's Insurance coverage to see what, if any, on-going therapy or hospital care is covered, and make sure you are getting the most from your provider.

Hospital Name:_____
Address:_____
City, State, Zip_____Website:_____
Switchboard Number:_____ Emergency Room Extension:_____

Medical Record #		
Physician:		
Additional Contact Person:		
Summary of Treatment Provided:		
Phone:	Fax:	Email:

Clinic Name and location		
Medical Record #		
Physician/Therapist(s):		
Treatment Type:		
Phone:	Fax:	Email:

Clinic Name and location		
Medical Record #		
Physician/Therapist(s):		
Treatment Type:		
Phone:	Fax:	Email:

SUMMARY OF CARE
HOSPITAL STAYS

Date	Hospital	Reason for Stay	Follow up

MEDICAL VISIT CHECK SHEET

Use this page to prepare for and track medical appointments.

My child's name is: _____ Today's Date: _____

Reason for today's visit:

My biggest concerns are:

Weight: _____
Height:_____

Current Medications:

Doctor's Notes / Today's Diagnosis:

Medication and Instructions:

Follow up Plan:

SUMMARY OF CARE
MEDICATION INFORMATION

Pharmacy: _____Phone:_____

Address: _____Fax:_____

Allergies to Medications:_____

Medication & Prescription Number	Date Started	Date Stopped	Dosage	Directions: (how much, time given, delivery method, side effects, special instructions)	Prescribed by: (name/ phone)

Medication & Prescription Number	Date Started	Date Stopped	Dosage	Directions: (how much, time given, delivery method, side effects, special instructions)	Prescribed by: (name/ phone)

SERVICE PROVIDERS
MEDICAL / DENTAL

Primary Care Provider:

Date of First Visit:_____ Medical Record #:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Developmental Pediatrician:

Date of First Visit:_____ Medical Record #:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Preferred Hospital:

Date of First Visit:_____ Medical Record #:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Dentist:

Date of First Visit:_____ Medical Record #:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Orthodonist:

Date of First Visit:_____ Medical Record #:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Specialty Care Provider:

Date of First Visit:_____ Medical Record #:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Specialty Care Provider:

Date of First Visit:____________________ Medical Record #:________________________
Address:____
Phone:_____________________Fax:___________________Email:_____________________
Website:____

Specialty Care Provider:

Date of First Visit:____________________ Medical Record #:________________________
Address:____
Phone:______________________Fax:__________________Email:_____________________
Website:____

Specialty Care Provider:

Date of First Visit:_____________________ Medical Record #:_______________________
Address:____
Phone:_______________________Fax:__________________Email:____________________
Website:____

Specialty Care Provider:

Date of First Visit:____________________ Medical Record #:________________________
Address:____
Phone:______________________Fax:__________________Email:_____________________
Website:____

Specialty Care Provider:

Date of First Visit:_____________________ Medical Record #:_______________________
Address:____
Phone:_______________________Fax:__________________Email:____________________
Website:____

SERVICE PROVIDERS
THERAPISTS

Occupational Therapist (OT):

Date of First Visit:_____ Medical Record #:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Speech-Language Therapist (SLP):

Date of First Visit:_____ Medical Record #:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Physical Therapist (PT):

Date of First Visit:_____ Medical Record #:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Mental Health Therapist:

Date of First Visit:_____ Medical Record #:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Audiologist:

Date of First Visit:_____ Medical Record #:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Specialty Care Provider:

Website:_____

SERVICE PROVIDERS
EQUIPMENT / SUPPLIES

Name of Equipment:

Description: (brand, model number, size)

Date obtained:_____ Supplier:_____
Contact Person:_____
Phone:_____Fax:_____Email:_____
Website:_____

Name of Equipment:

Description: (brand, model number, size)

Date obtained:_____ Supplier:_____
Contact Person:_____
Phone:_____Fax:_____Email:_____
Website:_____

Name of Equipment:

Description: (brand, model number, size)

Date obtained:_____ Supplier:_____
Contact Person:_____
Phone:_____Fax:_____Email:_____
Website:_____

Name of Equipment:

Description: (brand, model number, size)

Date obtained:_____ Supplier:_____
Contact Person:_____
Phone:_____Fax:_____Email:_____
Website:_____

SUMMARY OF CARE
SKIN CONDITIONS

Use this page to track any of your child's special skin or hair care needs, including sensitivity or allergies to scents.

What is the overall condition of your child's skin?:

☐ good ☐ dry ☐ rashes ☐ bruises ☐ bed sores ☐ wounds

How do you treat any skin problems?

What hair care product(s) do you use for your child?:

-
-
-

What skin care product(s) do you use for your child?:

-
-
-

What other helpful skin care items do you use for your child?:

-
-
-

Other comments or helpful information:

SUMMARY OF CARE
SEIZURE CONDITIONS

☐ *Does not apply to my child*

If your child has experienced seizures, please describe:
(duration, type of body movement, color changes that occur, recognized triggers)

_____
_____
_____

How often does your child have seizures?: ☐ more than 1x a day ☐ weekly ☐ monthly

How do you treat seizures that last longer than 5 minutes?:

_____
_____
_____

Does your child have a vagal nerve stimulator? ☐ yes ☐ no

Does your child have a VP shunt? ☐ yes ☐ no

If yes, what was the date of its last revision? _____

Is your child currently, or have they ever, been on the ketogenic diet? ☐ yes ☐ no

Which diagnostic studies has your child received? (Please list date and result):

☐CT scan:_____
☐MRI: _____
☐EEG:_____

Please list all seizure medications your child is currently taking:

-
-
-

Which seizure medications has your child tried **in the past**, *but is not currently taking?*

☐ Depakote ☐ Depakene ☐ Dilantin ☐ Felbatol

☐ Gabitril ☐ Lamictal ☐ Phenobarbital ☐ Tegretol

☐ Topiramate ☐ other _____

SUMMARY OF CARE
SENSORY AND COMMUNICATION

Vision:

Clinic:_____ Ophthalmologist/ Optometrist:_____

Date of first visit:_____ Medical record #:_____

Address:_____

Phone:_____Fax:_____Email:_____

Website:_____

Last date of vision exam:_____

Results, if known:

☐ Glasses ☐ Contact lens ☐ Prosthesis ☐ Other _____

☐ Surgery/Lasik ☐ History of ROP (retinopathy or prematurity)

Other comments or helpful information:

Audiology/Hearing:

Clinic:_____ Audiologist:_____

Date of first visit:_____ Medical record #:_____

Address:_____

Phone:_____Fax:_____Email:_____

Website:_____

Last date of hearing exam:_____

Additional tests:_____

Results:_____

Additional Tests:_____

Results:_____

☐ Wears aids ☐ Right ear ☐ Left ear ☐ Both ears

Other comments or helpful information:

Speech and Communication:

Clinic:_____

Speech & language pathologist:_____

Date of first visit:_____ Medical record #:_____

Address:_____

Phone:_____Fax:_____Email:_____

Website:_____

Results of evaluations:_____

_____

_____

Child uses following devices to meet communication needs:

☐ Computer ☐ Sign language (ASL) ☐ Communication board

☐ Interpreter services ☐ Lip reads ☐ Communication book

☐ Sign language (English) ☐ Other _____

Other comments or helpful information:

SUMMARY OF CARE
BREATHING/RESPIRATORY

☐ *Does not apply to my child*

Does your child have history of breathing problems? ☐ yes ☐ no

Use this page to detail your child's respiratory history and care needs.

☐ asthma ☐ pneumonia ☐ cystic fibrosis ☐ tuberculosis

☐ apnea (not breathing) ☐ other _____

Additional information:

Does your child have a tracheostomy? ☐ Yes ☐ No

Brand and size _____

Does your child require oxygen treatments? ☐ Yes ☐ No

If yes, how often?

☐ never ☐ intermittently ☐ continuously

Check if your child uses:

☐ Ventilator: type _____ ☐ CPAP machine ☐ monitor ☐ pulse oximeter

Setting information:_____

What kind of breathing treatments or medications does your child require?

☐ Albuterol nebulizer? Or puffs ? ☐ suctioning ☐ clapping (CPT)

☐ Intal nebulizer? Or puffs? ☐ mist ☐ oxygen

☐ Liters ☐ Provental nebulizer? Or puffs?

Other comments or helpful information:

SUMMARY OF CARE
PAIN MANAGEMENT

☐ *Does not apply to my child*

Does your child have pain concerns?

☐ always (daily) ☐ often (less than daily) ☐ not at all

What would best describe your child's usual pain level?

☐ mild ☐ moderate ☐ severe

How does your child indicate they are in pain?:

Do you use medications or treatments to alleviate your child's pain?: ☐ Yes ☐ No

If yes, please list:

If yes, at what point do you administer this treatment?

Other comments or helpful information:

SUMMARY OF CARE
HEART/CARDIAC

☐ *Does not apply to my child*

Name of heart condition:

Has your child had surgery for a heart problem? ☐ yes ☐ no

Date of surgery _____

Date of surgery _____

Date of surgery _____

Did the surgery correct the problem? ☐ yes ☐ no

Does your child have a pacemaker? ☐ yes ☐ no

Does your child have/take any medications regularly for the heart? ☐ yes ☐ no

If yes, please describe:

Other comments or helpful information:

SUMMARY OF CARE
MUSCLE / BONE ISSUES

☐ *Does not apply to my child*

Does your child currently have, or has he/she ever had:

☐ spasticity (tight) ☐ "floppy" ☐ contractures ☐ scoliosis ☐ broken bones:

☐ club foot ☐ tethered cord

Explain: _____

Has your child had orthopedic (bone) surgery? ☐ yes ☐ no

If yes, please explain: _____
_____
_____
_____

Does your child have a baclofen pump? ☐ yes ☐ no

Other comments or helpful information:

SUMMARY OF CARE
DENTAL CARE

Dental clinic:_____

Dentist:_____ Date of first visit:_____

Address:_____

_____

Phone:_____Fax:_____Email:_____

To prevent dental problems, all children should have routine dental care beginning when the first tooth appears or before their first birthday (American Academy of Pediatric Dentistry). Such care may be even more important if the child has special health needs. Before the child is examined, the dentist should have knowledge of the child's current medical condition(s) and treatment(s). It is essential that the dentist have a comprehensive, current list of all medications taken by the child.

☐ Dentist has been made aware of child's medical conditions and recommendations of medical specialists.

Has child had any problems or bad reactions to any previous dental treatment, surgery or anesthesia? ☐ Yes ☐ No

If yes, explain:_____

Has child had any anxiety, sensory challenges, or adverse emotional responses at any previous dental appointment? ☐ Yes ☐ No

If yes, explain how we can help your child cope:_____

_____

Has child experienced any abnormal bleeding (excessive bleeding or bruising) during any previous treatment? ☐ Yes ☐ No

If yes, explain:_____

Other comments or helpful information:

SUMMARY OF CARE
DENTAL RECORD

Date	Procedure/ Reason for Visit	Results	Follow up

SUMMARY OF CARE
BEHAVIORAL HEALTH
COPING & STRESS TOLERANCE

Child's IQ measurement:_____ Adaptive Age:_____

Date of IQ Evaluation:_____ Date of Age Evaluation:_____

☐ Child's IQ has not been evaluated ☐ Adaptive Age has not been evaluated

Sensory Modulation:

Does your child react too much or not enough to sensory stimulus (sounds, touch, light, scents)?

If yes, please explain_____

_____

Interpersonal Skills:

Does your child best respond to adults who are fast-paced? Patient and Calm? Structured or Unstructured? How does she/he get along in groups of children? _____

_____

Social Skills:

Is your child out-going or reserved? How does your child cope in social situations? Is she/he able to read social cues?_____

_____

Emotional Modulation:

Does your child experience "melt-downs"? What behaviors might they exhibit prior to a meltdown? Is he/she affected by noisy or hectic situations? Is your child easily frustrated? What scenarios could cause negative emotional responses? _____

_____

_____

_____

_____

How does your child calm themselves? _____

How can adults help calm your child?_____

How does your child cope with transition?_____

How does your child ask for help?_____

_____

What techniques, words, reward systems do you use to assist your child when they are frustrated, anxious, over-stimulated, etc?_____

_____

_____

Describe situations or scenarios that would be difficult for your child and how you would comfort them?

FAMILY AND DAILY ROUTINES

This section provides information that you or another caregiver might need in providing daily care for your child. Information includes:

- Child's personal statement
- Family's Circle of Support
- Lists of Services Providers
- Information about:
  - Diet
  - Toileting
  - Milestones
  - Routine
  - Sleep Needs and Patterns
  - Communication
  - Mobility
  - Social Play
  - In home Care
  - Transportation

GET TO KNOW ME!

My Name:_____ My Nickname:_____

My Birthday:_____Today's Date:_____

Who am I? Here is how I describe myself:

My strengths and interests are:

My challenges are:

My community: (school, childcare, favorite places to go, eat, visit)

My Family and Home: (who lives in my house? Brothers or sisters? Grandparents?)

My diagnosis is:

OUR FAMILY'S CIRCLE OF SUPPORT

Use this page to help you think about people, groups, agencies and programs that can offer practical, logistical or emotional support to your family and your child. This list will grow and evolve as you expand your circle.

People and Organizations:	**Email/Phone**	**Support they provide**
Family Members:		
_____	_____	_____
_____	_____	_____
_____	_____	_____
Friends:		
_____	_____	_____
_____	_____	_____
_____	_____	_____
School Staff:		
_____	_____	_____
_____	_____	_____
_____	_____	_____
Paid, Volunteer or Cooperative Respite Care:		
_____	_____	_____
_____	_____	_____
_____	_____	_____
Faith Community:		
_____	_____	_____
_____	_____	_____
_____	_____	_____
Community Programs or Support Groups:		
_____	_____	_____
_____	_____	_____
_____	_____	_____

SERVICE PROVIDERS
FAMILY SUPPORT

Parent to Parent program:

Contact person:_____
Address: _____
Phone:_____Fax:_____Email:_____
Website:_____

Parent group or class:

Contact person:_____
Address: _____
Phone:_____Fax:_____Email:_____
Website:_____

Faith-based or religious organization:

Contact person:_____
Address: _____
Phone:_____Fax:_____Email:_____
Website:_____

Behavior health or counseling services:

Contact person:_____
Address: _____
Phone:_____Fax:_____Email:_____
Website:_____

SUMMARY OF CARE
DIET AND NUTRITION

My child is/was breast fed. ☐ yes ☐ no

If your child is currently breast feeding, how often?

☐ every 1.5 hours ☐ every 2-3 hours ☐ every 4 hours ☐

If your child is currently being fed formula, please list brand: _____

How often is your child fed each day?

☐ every 1.5 hours ☐ every 2-3 hours ☐ every 4 hours ☐ _____

Does your child require any nutritional supplements? ☐ yes ☐ no

If yes, please list:_____

Please list any known allergies or restrictions to food:

Please list any special techniques, precautions or equipment used during feeding:

Does your family have any special routines that help during feeding? Please list:

Other comments or helpful information:

SUMMARY OF CARE
TOILETING

- Is your child potty-trained ☐ yes ☐ no
  If yes, age of child? _____
- How often does your child have a bowel movement?

  ☐ daily ☐ every 2-3 days ☐ 4 days or longer

Special toileting needs:

☐ *Does not apply to my child*

- Does your child have bladder control? ☐ yes ☐ no
- Does your child have a history of urinary tract infections? ☐ yes ☐ no
- Does your child have bowel control? ☐ yes ☐ no
- Does your child have history of constipation / impaction? ☐ yes ☐ no
- Does your child suffer from diarrhea? ☐ yes ☐ no
- Does your child use laxatives? ☐ yes ☐ no
  (Check all that apply)

  ☐ colace ☐ lactulose ☐ milk of magnesia

  ☐ mineral oil ☐ senna ☐ miralax ☐ other_____
- Does your child use suppositories or enemas? ☐ yes ☐ no

  ☐ bisacodyl (dulcolax) ☐ saline enema ☐ phosphate enema

  ☐ glycerin adult? Pediatric? Or infant? (Fleets) ☐ other _____

Does your child have a toileting program? ☐ yes ☐ no

If yes, please describe: _____
_____
_____

Other comments or helpful information:

SUMMARY OF CARE
TRACKING MILESTONES

	DATE/AGE	NOTES
Lifted head while on tummy		
Rolled over –tummy to back		
Sat with support		
Rolled over- back to tummy		
Sat without support		
Pulled to stand with support		
Started cruising		
Stood without support		
First steps without support		
Walked		
Started solid foods		
Started babbling		
First words		
First started to speak in sentences		

MY CHILD'S DAILY ROUTINE

Use this page to communicate your child's routine with caregivers	
Morning routine	
My child is ready to get out of bed when…..	
First thing in the morning, my child will…	
Favorite clothing	
Where shoes are usually hiding	
Routines that make dressing easier	
Toys that make mornings better	
For breakfast my child usually eats…	
Foods to avoid	
Usual length of time to eat	
Signs my child is full	
Ways to encourage better eating	

Use this page to communicate your child's routine with caregivers	
Some areas are off-limits to my child in the house	
How to calm or soothe my child	
Daytime routine	
We take a walk to:	
Favorites songs to listen to	
Favorite shows to watch	
Favorite books to read	
Signs my child is needing a nap or quiet time	
Nap times (hints for success)	
Snack times (hints for success)	
For Lunch, my child likes to eat…	
Foods to avoid	
Usual length of time to eat	
Signs my child is full	

Use this page to communicate your child's routine with caregivers	
Evening routine	
For dinner, my child likes to eat	
Foods to avoid	
Usual length of time to eat	
Signs my child is full	
Ways to encourage better eating	
Signs my child is ready for sleep	
Bedtime ritual and toys	
What to avoid in the bedroom	
What my child wears to sleep	
What helps my child fall asleep	
What cues help keep my child in bed	
Best methods for giving medication are	
Where the medications are kept	

Use this page to communicate your child's routine with caregivers	
TV rules	
Radio rules	
Music rules	
Computer or video game rules	

Other comments or information:

MY CHILD'S REST AND SLEEP PATTERNS

Use this page to describe your child's sleep habits and routines. Mention any items they need for comfort or reassurance.

How my child sleeps	
Tools/equipment that help with sleep	
Routines and rituals that help with sleep	
Security/comfort objects that help with sleep	
Positioning information and routines	
Medication information and schedule	

Other comments or helpful information:

MY CHILD'S COMMUNICATION

Use this page to share your child's communication skills, tools and ability. Include sign language, equipment, picture symbols, etc. that your child uses to communicate.

How my child communicates	
Tools that help my child communicate	
Gestures/images my child uses to show fear	
Gestures/images my child uses to show hunger	
Gestures/images my child uses to show toileting needs	
Gestures/ images my child uses to show:	
Gestures/images my child uses to show:	
Gestures/images my child uses to show:	

Other comments or helpful information:

MY CHILD'S MOBILITY

Use this page to share information about your child's ability to get about. Include information regarding assistance they may require, equipment they use, or information regarding transfers, positioning, etc.

How my child moves about	
Tools/equipment that aid in movement	
Actions my child can take without assistance	
Motor activities my child needs assistance with	
Positioning information and routines	
Transfer information and routines	

Other comments or helpful information:

MY CHILD'S SOCIAL/ PLAY INFORMATION

Use this page to describe your child's interactions and how they get along with others. Are there routines or language that encourages your child to play and cooperate with others? Do you have tools that help them make transition to other activities?

How my child indicates affection	
How my child indicates fear	
How my child plays with other children	
My child's favorite activity with others	
What encourages my child to cooperate	
What helps my child transition from one task to another	

Other comments or helpful information:

SERVICE PROVIDER
IN-HOME CARE

Use this form to track in-home nursing, respite, or child care options.

Provider:_____Contact:_____
Agency:_____Availability:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Provider:_____Contact:_____
Agency:_____Availability:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Provider:_____Contact:_____
Agency:_____Availability:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Preferred alternate staff:_____
Agency:_____Availability:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Other options:

SERVICE PROVIDER TRANSPORTATION

☐ *Does not apply to my child*

School transportation (company name):

Contact person:_____
Phone:_____Fax:_____
Website:_____
Tips for successful scheduling:_____
_____

Days using school transport:

Monday	Tuesday	Wednesday	Thursday	Friday
am/pm	am/pm	am/pm	am/pm	am/pm

Medical appointment transport (company name):

Contact person:_____
Phone:_____Fax:_____
Website:_____
Tips for successful scheduling:_____
_____

Days using school transport:

Monday	Tuesday	Wednesday	Thursday	Friday
am/pm	am/pm	am/pm	am/pm	am/pm

Additional transportation needs (company name):

Contact person:_____
Phone:_____Fax:_____
Website:_____
Tips for successful scheduling:_____
_____

SCHOOL INFORMATION

This section identifies a location to keep and track the paperwork, evaluations, and plans generated in the school environment.

Suggested Information to Include:

- Copies of Individual Family Service Plan (IFSP's)
- Copies of Individualized Education Plans (IEP's)
- Report cards
- School evaluations
- School communication log
- Transition plans
- Post -secondary Information and plans
- School based behavior plans

SERVICE PROVIDERS
EARLY INTERVENTION

County Educational School District:_____

Start date:_____ End date:_____
Contact:_____ Contact:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Family resource coordinator:_____

Additional contact:_____
Start date:_____ End date:_____
Contact:_____ Contact:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Teacher/therapist:_____

Start date:_____ End date:_____
Address:_____
Phone:_____Fax:_____Email:_____

Teacher/therapist:_____

Start date:_____ End date:_____
Address:_____
Phone:_____Fax:_____Email:_____

SERVICE PROVIDERS
SCHOOLS

Preschool:_____

Director:_____ Teacher/s:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Days attending:

Monday	Tuesday	Wednesday	Thursday	Friday
am/pm	am/pm	am/pm	am/pm	am/pm

School:_____

Principal:_____ Teacher/s:_____
Special education staff:_____
School secretary:_____ School nurse_____
School guidance counselor:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Before or After-School Program:

Director:_____ Contact:_____
Address:_____
Phone:_____Fax:_____Email:_____
Website:_____

Days attending:

Monday	Tuesday	Wednesday	Thursday	Friday
am/pm	am/pm	am/pm	am/pm	am/pm

School transportation (company name):

Contact person:_____Phone:_____
Tips for successful scheduling:_____
_____

Days using school transport:

Monday	Tuesday	Wednesday	Thursday	Friday
am/pm	am/pm	am/pm	am/pm	am/pm

SUMMARY OF CARE
TRANSITION TO ADULTHOOD

Use this page from time to time to track the preparation for transition to adulthood and the responsibilities and opportunities that accompany it. While this list is far from comprehensive, we hope that it encourages dialogue and gathering of resources.

Date:_____ Age:_____

Self Care:	**Yes**	**No**	**Part Way There**
• I can take care of my personal grooming. (hair, bathing, teeth, dress)	☐	☐	☐
• I eat regular healthy foods and snacks.	☐	☐	☐
• I prepare my own meals and snacks	☐	☐	☐
• I avoid risky behaviors (including drugs and alcohol use)	☐	☐	☐
• I am active and exercise regularly.	☐	☐	☐
• I have a plan for what to do in case of natural disaster.	☐	☐	☐
• I have a good friends and am active in my community.	☐	☐	☐
• I have established a transportation plan and can use it as needed.	☐	☐	☐
• I can safely manage my money or have a trusted person helping me do this.	☐	☐	☐
• I understand and can recognize inappropriate contact by another person and know how to report it.	☐	☐	☐
• I have received information about puberty and my developing body and feelings.	☐	☐	☐

Health Care:

• I carry emergency health information and an Insurance card at all times.	☐	☐	☐
• I have found a doctor who will take care of me when I turn 18.	☐	☐	☐
• I can schedule and get to my appointments.	☐	☐	☐
• I have a list of my current medications and allergies to medications.	☐	☐	☐
• I know when and how to take my medications.	☐	☐	☐
• I can communicate my questions to my doctor.	☐	☐	☐
• I know my own health care needs.	☐	☐	☐
• I have a record of my immunizations.	☐	☐	☐

- I know how to get help with my insurance. ☐ ☐ ☐
- I have a list of all my specialist doctors. ☐ ☐ ☐
- I have access to health insurance when I become an adult. ☐ ☐ ☐

My Condition or Disability:

- I know how to find information about my condition/disability on the internet or at the library. ☐ ☐ ☐
- I can describe my condition/disability to my family and friends. ☐ ☐ ☐
- I know what accommodations I need to be successful at school or work and can explain them. ☐ ☐ ☐
- I can explain my disability to a new or unfamiliar doctor. ☐ ☐ ☐
- I know resources specific to my condition/ disability in my community. ☐ ☐ ☐

Community/Governmental Resources

- My family and I know about Supplemental Security Income/Social Security ☐ ☐ ☐
- My family and I have discussed guardianship. ☐ ☐ ☐
- I have acquired photo Identification (State ID). ☐ ☐ ☐
- I have my Social Security card. ☐ ☐ ☐

Education:

- I have participated in my IEP meetings and understand my transition goals and timeline. ☐ ☐ ☐
- I have made decisions about my plans after high school. ☐ ☐ ☐
- I know about the Division of Vocational Rehabilitation and how it can help me. ☐ ☐ ☐

SCHOOL COMMUNICATION RECORD

You can use this document to record episodes, communication and follow up incidents that occur while your child is at school.

Date	Description of Incident	Communicated by:	Follow up

SUMMARY OF CARE
NOTES

SUMMARY OF CARE

NOTES