



Emergency Information Form for Children With Special Needs



American College of
Emergency Physicians®

American Academy
of Pediatrics



Date form
completed
By Whom

Revised
Revised

Initials
Initials

Name:		Birth date:	Nickname:
Home Address:		Home/Work Phone:	
Parent/Guardian:	Emergency Contact Names & 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





**Cheyenne Regional
Medical Center**

**Emergency Information
Children With Special Needs**

STAMPER OR PATIENT LABEL

Diagnoses/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						Dates					
DPT						Hep B					
OPV						Varicella					
MMR						TB status					
HIB						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:

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