



Emergency Information for Special Needs

Date form completed:
By whom:

Name:	Birthdate:
Address:	Parent/Guardian:
Phone Number(s):	Signature*:
2nd Contact & Relationship:	Phone Number(s):

Diagnoses (starting with most important)	
Baseline Physical Findings	
Baseline Vital Signs	BP: / HR: SpO2: Temp:
Baseline Neurologic Status	
Prostheses, Appliances, Advanced Tech. Device, Life Support	
Immunologic Competency Status	

Medications (dose, purpose)	
Allergies: Medications, foods, substances to avoid and why	
Advanced Directives (include date of last review)	
Antibiotic Prophylaxis (drug, dose, indication)	

Care Provider	Provider's Name	Specialties	Contact numbers
Primary Care			Emergency: Regular:
Specialist 1			Emergency: Regular:
Specialist 2			Emergency: Regular:

DPT dates		Hep B dates		Procedures to avoid and why	
Dtap dates		Hep A dates			
OPV or IPV dates		Meningococcal		Level of Executive Functioning (making own decisions, self-control, working memory, etc.)	
MMR dates		TB status			
HiB dates		HP virus		Sensitivities (including sensory)	
Pneumococcal-7		Covid dates			
Varicella status		Other			

Common Presenting Problem/ Findings	Suggested Diagnostic Studies	Treatment Recommendations



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Guardian Signature*:

Communication	<input type="checkbox"/> Speaks in full sentences <input type="checkbox"/> Speaks in short phrases <input type="checkbox"/> Speaks 1-2 word responses <input type="checkbox"/> Non-verbal <input type="checkbox"/> Uses a communication device:
Communicates best using	<input type="checkbox"/> Spoken language <input type="checkbox"/> Pictures <input type="checkbox"/> Written words
Specific interests or favorite objects	1) 2) 3)
Dislikes or upsetting things	1) 2) 3)
Suggestions	<input type="checkbox"/> Use simple, direct language <input type="checkbox"/> Allow time for processing questions or instructions <input type="checkbox"/> Provide 2-3 choices <input type="checkbox"/> Give '2 minute' warning before changes/transitions <input type="checkbox"/> Keep lights dimmed <input type="checkbox"/> Keep noise levels low <input type="checkbox"/> Model any necessary procedures <input type="checkbox"/> Create a visual schedule <input type="checkbox"/> Create a written schedule <input type="checkbox"/> Earn a reinforcer at the end of the visit like:
Other Comments	

Comments on individual, family, or other specific medical issues:

Provider Signature (optional):

Name: