EMERGENCY INFORMATION

*if more space is needed for any section, additional information can be added to the end of this document

Child's name: Date of Birth:

CODE STATUS: Briefly describe current code status (e.g. full code, DNR, etc)

CONTACT INFORMATION:

Parent/Guardian 1: Name:

Phone:

E-Mail:

Parent/Guardian 2: Name:

Phone:

E-mail:

Pediatrician: Name/Practice:

Phone:

Emergency Contact Name:

Phone:

MAIN DIAGNOSES List main diagnoses that would be relevant in an emergency

1.
2.
3.
4.
5.

IMPORTANT INFORMATION Select important factors that would be relevant in an emergency

- ☐ Allergies (list):
- ☐ Tracheostomy (type/size): ☐ Ventilator dependent ☐ O2 dependent
- ☐ Other breathing support (list):
- ☐ Feeding tube: (type/size): Feeding tube used for: ☐ all nutrition ☐ some nutrition ☐ medications
- ☐ NPO (nothing by mouth
- ☐ Non ambulatory: Requires: ☐ Full support ☐ Partial support
- ☐ Seizures
- ☐ Other: (describe)

DAILY MEDICAL INTERVENTIONS: List and describe any daily medical interventions such as airway clearance, nebulizer treatments, dressing changes, straight catheter, etc. **Include any necessary settings**

Intervention:

Frequency:

Settings (include both well and sick settings):

Intervention:

Frequency:

Settings (include both well and sick settings):

Daily Medical Interventions continued:

Intervention

Frequency

Settings (include both well and sick settings):

Intervention

Frequency

Settings (include both well and sick settings):

NUTRITION: List and describe any nutrition information such as method of intake (g-tube, by mouth), caloric intake, special diets/formulas, pump settings if applicable

MEDICATIONS: (indicate if a medication is “as needed” with “PRN” under Time Administered)

Medication/ Suspension info	**Dosage/Amount administered**	**Time(s) administered**	**Purpose/Prescribing doctor**

☐ *continued on next page*

MEDICATIONS: (Indicate if a medication is “as needed” with “**PRN**” under Time Administered)

Medication/ Suspension info	**Dosage/Amount administered**	**Time(s) administered**	**Purpose/Prescribing doctor**

SURGICAL HISTORY

Date	Procedure	Hospital/Surgeon

OTHER INPATIENT HOSPITALIZATIONS

Dates admitted	Reason	Hospital

ADDITIONAL CONTACT INFO/SPECIALISTS

Insurance Case Manager: Phone:

Insurance Case Manager (secondary): Phone:

Specialty:

Doctor/Practice Name and Phone:

Specialty:

Doctor/Practice Name and Phone:

Specialty:

Doctor/Practice Name and Phone:

Specialty:

Doctor/Practice Name and Phone:

Specialty:

Doctor/Practice Name and Phone:

Specialty:

Doctor/Practice Name and Phone:

Additional Information

add any additional information that did not fit above, or any important information you would need in an emergency