Key Contacts

Family

Parent/Guardian _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Parent/Guardian _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Relative/Relationship _____

Phone # _____

Relative/Relationship _____

Phone # _____

Relative/Relationship _____

Phone # _____

Medical

Emergency _____ Poison Control # _____

Fire # _____ Police # _____

Pharmacy _____

Phone # _____

Therapy _____

Phone # _____

Hospital _____

Phone # _____

School

School _____

Phone # _____

School _____

Phone # _____

Doctor/Specialty

Doctor/Specialty _____

Phone # _____

Doctor/Specialty _____

Phone # _____

Doctor/Specialty _____

Phone # _____

Doctor/Specialty _____

Phone # _____

Doctor/Specialty _____

Phone # _____

Doctor/Specialty _____

Phone # _____

Doctor/Specialty _____

Phone # _____

Doctor/Specialty _____

Phone # _____

Doctor/Specialty _____

Phone # _____

Doctor/Specialty _____

Phone # _____

Special Transportation

Medical Appts/Phone# _____

School/Phone# _____

Utilities (contact each for a Medical Necessity Form)

Gas _____ Phone # _____ Acct # _____

Electric _____ Phone # _____ Acct # _____

Water _____ Phone # _____ Acct # _____

Phone _____ Phone # _____ Acct # _____

Other _____

Phone # _____

Other _____

Phone # _____

Doctors/Therapists

Doctors

Primary Care _____
Location _____
Address _____
Phone _____ Fax _____ Email _____
Emergency _____

Specialist _____
Location _____
Address _____
Phone _____ Fax _____ Email _____
Emergency _____

Specialist _____
Location _____
Address _____
Phone _____ Fax _____ Email _____
Emergency _____

Specialist _____
Location _____
Address _____
Phone _____ Fax _____ Email _____
Emergency _____

Specialist _____
Location _____
Address _____
Phone _____ Fax _____ Email _____
Emergency _____

Specialist _____
Location _____
Address _____
Phone _____ Fax _____ Email _____
Emergency _____

Professional Resources

Name _____
Location _____
Address _____
Phone _____ Fax _____ Email _____
Emergency _____

Name _____
Location _____
Address _____
Phone _____ Fax _____ Email _____
Emergency _____

Name _____
Location _____
Address _____
Phone _____ Fax _____ Email _____
Emergency _____

Name _____
Location _____
Address _____
Phone _____ Fax _____ Email _____
Emergency _____

Name _____
Location _____
Address _____
Phone _____ Fax _____ Email _____
Emergency _____

Pharmacies/Hospitals

Pharmacies

Main _____
Address _____
Phone _____ Fax _____ Email _____
Business Hours _____ Contact _____

Other _____
Address _____
Phone _____ Fax _____ Email _____
Business Hours _____ Contact _____

Other _____
Address _____
Phone _____ Fax _____ Email _____
Business Hours _____ Contact _____

Other _____
Address _____
Phone _____ Fax _____ Email _____
Business Hours _____ Contact _____

Other _____
Address _____
Phone _____ Fax _____ Email _____
Business Hours _____ Contact _____

Other _____
Address _____
Phone _____ Fax _____ Email _____
Business Hours _____ Contact _____

Hospitals

Main _____
Address _____
Medical Record # _____
Hospital Operator # _____
Emergency Department # _____
Contact/Title _____
Phone _____ Fax _____ Email _____

Other _____
Address _____
Medical Record # _____
Hospital Operator # _____
Emergency Department # _____
Contact/Title _____
Phone _____ Fax _____ Email _____

Notes

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Transportation

Ambulance
Company _____
Address _____
Phone _____ Fax _____ Email _____

Special Transportation (to and from medical/therapy appointments)
Contact _____
Agency _____
Address _____
Phone _____ Fax _____ Email _____
Important Information (bus route, rules regarding pick-up, etc.)
_____
_____
_____
_____
_____

Special Transportation (to and from medical/therapy appointments)
Contact _____
Agency _____
Address _____
Phone _____ Fax _____ Email _____
Important Information (bus route, rules regarding pick-up, etc.)
_____
_____
_____
_____
_____

Special Transportation (to and from school)
Contact _____
Agency _____
Address _____
Phone _____ Fax _____ Email _____
Important Information (bus route, rules regarding pick-up, etc.)
_____
_____
_____
_____
_____

Notes

School/Daycare

School Name _____
Address _____
Phone _____ Fax _____ Email _____

Nurse _____
Phone # _____

Teacher _____
Phone # _____

Teacher _____
Phone # _____

Principal _____
Phone # _____

Guidance Counselor _____
Phone # _____

Special Education Director _____
Phone # _____

Transportation Contact _____
Phone # _____

Homebound Coordinator _____
Phone # _____

Additional Contacts (PT, OT, Nutritionist, Therapist, etc.)

Name _____
Title _____
Phone _____ Fax _____ Email _____

Name _____
Title _____
Phone _____ Fax _____ Email _____

Name _____
Title _____
Phone _____ Fax _____ Email _____

Name _____
Title _____
Phone _____ Fax _____ Email _____

Name _____
Title _____
Phone _____ Fax _____ Email _____

Name _____
Title _____
Phone _____ Fax _____ Email _____

Name _____
Title _____
Phone _____ Fax _____ Email _____

Name _____
Title _____
Phone _____ Fax _____ Email _____

Notes

Caregiver

Parent/Guardian _____

Will be at _____ phone _____cell _____

Will be home at _____

Special instructions _____

_____

_____

_____

Significant events in the past 48 hours _____

_____

_____

_____

Medications

Name	Strength	Dosage	Time to be given

Call 911 in case of emergency.

Child's Name _____ Date of Birth _____

Home Phone _____

Address _____

_____

Primary Care Doctor/Phone _____

Other person to call in case of emergency _____

In home

Extra equipment/supplies are located _____

_____

Fuse box or breaker box is located _____

Fire extinguisher is located _____

Flashlights are located _____

For EMT or ER personnel

Allergies _____

_____

Baseline data _____

_____

Pulse rate _____ Site best taken _____

BP_____ Site best taken_____

Temp_____ Site best taken_____

Resp rate/minute_____ Oxygen saturation_____

Skin color_____ Best blood draw site_____

Pupils _____

Communication

Preferred method _____ Language _____

How child expresses pain _____

_____

These things can upset or overstimulate my child

(loud noises, bright lights, medical equipment, separation from parents/special item, touch, etc.)

_____

_____

These things can help calm my child

_____

_____

Insurance

Company _____ Policy # _____

Policyholder Name _____ Group # _____

Caregiver

Parent/Guardian _____

Will be at _____ phone _____cell _____

Will be home at _____

Special instructions _____

_____

_____

_____

Significant events in the past 48 hours _____

_____

_____

_____

Medications

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Flashlights are located _____

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Allergies _____

_____

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Pulse rate _____ Site best taken _____

BP_____ Site best taken_____

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Policyholder Name _____ Group # _____

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Will be home at _____

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_____

Insurance

Company _____ Policy # _____

Policyholder Name _____ Group # _____