# Sample Medical Summary and Emergency Care Plan

This document should be shared with the youth and parent/caregiver.
Attach the immunization record to this form.

## CONTACT INFORMATION

*Preferred name* | *Legal name*

*Date of birth* | *Preferred language*

*Address*

*Cell phone/Home phone* | *Best time to reach*

*Email* | *Best way to reach (text, phone, email)*

*Health insurance and/or plan* | *Group and ID numbers*

*Parent/Caregiver name* | *Relationship* | *Phone*

## PLEASE SHARE SOME SPECIAL INFORMATION THAT THE YOUTH OR PARENT/CAREGIVER WANTS THEIR NEW HEALTH CARE CLINICIAN TO KNOW *(e.g., they enjoy baseball, they play the piano).*

## EMERGENCY CARE PLAN

☐ Limited decision-making legal documents available, if needed ☐ Disaster preparedness plan completed

*Emergency contact* | *Relationship* | *Phone*

*Preferred emergency care location*

| Common Emergent Presenting Problems | Suggested Tests | Treatment Considerations |
|---|---|---|
| | | |
| | | |
| | | |
| | | |





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# Sample Medical Summary and Emergency Care Plan
*(Continued)*

## ALLERGIES AND PROCEDURES TO BE AVOIDED

| Allergies | Reactions |
|---|---|
| | |
| | |

| To Be Avoided | Why? |
|---|---|
| ☐ Medical procedures | |
| ☐ Medications | |

## DIAGNOSES AND CURRENT PROBLEMS

| Problem | Details and Recommendations |
|---|---|
| ☐ Primary Diagnosis | |
| ☐ Secondary Diagnosis | |
| ☐ Behavioral | |
| ☐ Communication | |
| ☐ Feeding & Swallowing | |
| ☐ Hearing/Vision | |
| ☐ Learning | |
| ☐ Orthopedic/Musculoskeletal | |
| ☐ Physical Anomalies | |
| ☐ Respiratory | |
| ☐ Sensory | |
| ☐ Stamina/Fatigue | |
| ☐ Other | |

## MEDICATIONS

| Medications | Dose | Frequency | Medications | Dose | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |





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# Sample Medical Summary and Emergency Care Plan
*(Continued)*

## HEALTH CARE CLINICIANS

| | | |
|---|---|---|
| *Clinician's name* | *Primary/(Sub)specialty* | |
| *Clinic or Hospital* | *Phone* | *Fax* |
| *Clinician's name* | *Primary/(Sub)specialty* | |
| *Clinic or Hospital* | *Phone* | *Fax* |

## PRIOR SURGERIES, PROCEDURES, AND HOSPITALIZATIONS

| | |
|---|---|
| *Date* | *Surgery/Procedure/Hospitalization* |
| *Date* | *Surgery/Procedure/Hospitalization* |

## BASELINE

Vital Signs: *Height* *Weight* *RR* *HR* *BP*

*Neurological status*

## MOST RECENT LABS AND RADIOLOGY

| | | |
|---|---|---|
| *Test* | *Result* | *Date* |
| *Test* | *Result* | *Date* |
| *Test* | *Result* | *Date* |

## EQUIPMENT, APPLIANCES, AND ASSISTIVE TECHNOLOGY

- ☐ Gastrostomy
- ☐ Tracheostomy
- ☐ Suctions
- ☐ Nebulizer
- ☐ Communication Device
- ☐ Adaptive Seating
- ☐ Wheelchair
- ☐ Orthotics
- ☐ Crutches
- ☐ Walker
- ☐ Other(s): _____

Monitors:

- ☐ Apnea
- ☐ $O_2$
- ☐ Cardiac
- ☐ Glucose





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*(Continued)*

## SCHOOL AND COMMUNITY INFORMATION

| *Agency/School* | *Contact person* | *Phone* |
|---|---|---|
| *Agency/School* | *Contact person* | *Phone* |
| *Agency/School* | *Contact person* | *Phone* |

## IMPORTANT NEXT STEPS

*Next step(s)*

*Next appointment(s)*

| ***Youth signature*** | *Date* |
|---|---|
| *Print name* | *Phone* |
| ***Parent/Caregiver signature*** | *Date* |
| *Print name* | *Phone* |
| ***Clinician/Care staff signature*** | *Date* |
| *Print name* | *Phone* |





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