

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



Sample Medical Summary and Emergency Care Plan (Continued)

ALLERGIES AND PROCEDURES TO BE AVOIDED

Allergies	Reactions

To Be Avoided	Why?
<input type="checkbox"/> Medical procedures	
<input type="checkbox"/> Medications	

DIAGNOSES AND CURRENT PROBLEMS

Problem	Details and Recommendations
<input type="checkbox"/> Primary Diagnosis	
<input type="checkbox"/> Secondary Diagnosis	
<input type="checkbox"/> Behavioral	
<input type="checkbox"/> Communication	
<input type="checkbox"/> Feeding & Swallowing	
<input type="checkbox"/> Hearing/Vision	
<input type="checkbox"/> Learning	
<input type="checkbox"/> Orthopedic/Musculoskeletal	
<input type="checkbox"/> Physical Anomalies	
<input type="checkbox"/> Respiratory	
<input type="checkbox"/> Sensory	
<input type="checkbox"/> Stamina/Fatigue	
<input type="checkbox"/> Other	

MEDICATIONS

Medications	Dose	Frequency	Medications	Dose	Frequency

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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
 - O₂
 - Cardiac
 - Glucose

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SCHOOL AND COMMUNITY INFORMATION

<i>Agency/School</i>	<i>Contact person</i>	<i>Phone</i>
<i>Agency/School</i>	<i>Contact person</i>	<i>Phone</i>
<i>Agency/School</i>	<i>Contact person</i>	<i>Phone</i>

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*