

## **Health Summary for Your Child with Special Health Care Needs**

### **Want to get the best health care for your child?**

- 1) **Write down** your child's health care information as soon as you get it.
- 2) **Share** this information with your health care providers.

This form will help you keep track of the health information you'll need.

#### **Tips for using this form:**

- You don't have to fill out every line - just what applies to your child.
- Be sure to ask your health care provider if you have *any* questions or concerns.
- Protect your child's Social Security number and other personal information. Store completed copies of this form and other health records in a safe place at home.
- Remember to bring this form with you to appointments.

**For a blank form**, call the NYS Department of Health at 1-518-473-9883, or go to [www.health.ny.gov/community/special\\_needs](http://www.health.ny.gov/community/special_needs)

#### **Other health summary forms:**

**Health Care Notebook:** *Parent-to-Parent of New York State* is an organization that serves families of children with special health care needs. It has developed a Health Care Notebook that can be placed in a 3-ring binder. You can download a complete Health Care Notebook, or just the pages you need at the Parent-to-Parent website, [www.parenttoparentnys.org](http://www.parenttoparentnys.org). You can also call 1-800-305-8817 to get the number of your local Parent-to-Parent office.

**Emergency Information Form for Children with Special Needs:** Work with your health care provider to complete this form in case your child has an emergency. You or your doctor can find this form at: [www.aap.org/advocacy/blankform.pdf](http://www.aap.org/advocacy/blankform.pdf).

## Health Summary for Your Child with Special Health Care Needs

Name of Child: \_\_\_\_\_ DOB: \_\_\_\_\_

Child's Nickname: \_\_\_\_\_ Soc. Security #: \_\_\_\_\_  
(Optional)

Parent/Guardian: \_\_\_\_\_ Phone (home): \_\_\_\_\_

Parent/Guardian E-mail: \_\_\_\_\_ Phone (cell/work): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Child's Main Diagnosis: \_\_\_\_\_

Other Diagnoses or Major Injuries: \_\_\_\_\_

### Special Care Needs of Your Child

**Allergies:** Include medicine, food, environment, contact, or other. Also describe what happens.

1. \_\_\_\_\_ What happens: \_\_\_\_\_

2. \_\_\_\_\_ What happens: \_\_\_\_\_

3. \_\_\_\_\_ What happens: \_\_\_\_\_

• Main language, or way to communicate \_\_\_\_\_

• Describe any challenges with movement, hearing, eyesight, or thinking:

\_\_\_\_\_  
\_\_\_\_\_

• Special safety instructions/crisis plan: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

• Special conditions, treatment challenges, unusual findings, or equipment used (type & size):

\_\_\_\_\_  
\_\_\_\_\_

**Usual Doctor:** \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

Hospital you prefer: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Major Surgeries and Hospitalizations**

Where: \_\_\_\_\_ Why: \_\_\_\_\_ Date: \_\_\_\_\_

Where: \_\_\_\_\_ Why: \_\_\_\_\_ Date: \_\_\_\_\_

Where: \_\_\_\_\_ Why: \_\_\_\_\_ Date: \_\_\_\_\_

Where: \_\_\_\_\_ Why: \_\_\_\_\_ Date: \_\_\_\_\_

**Medicines (Drugs) your child is taking:**

Name of medicine	For what reason	Amount (Dose) and how often	Doctor who ordered

**Medicines (Drugs) tried in the past that didn't work, and what happened**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Additional Health Care Providers**

Name: \_\_\_\_\_ Reason: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Reason: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Reason: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Reason: \_\_\_\_\_ Phone: \_\_\_\_\_

**Usual Dentist:** \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

**Other Care Providers**

School Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Therapist: \_\_\_\_\_ Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Other: \_\_\_\_\_ Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Parent/Guardian: \_\_\_\_\_ page 3

<b>Immunizations (Shots)</b>	<b>Date</b>	<b>Date</b>	<b>Date</b>	<b>Date</b>	<b>Date</b>
Diphtheria Pertussis (DPT/DTaP) Tetanus					
Polio					
Mumps Measles (MMR) Rubella					
Hib (Haemophilus influenza type b)					
Pneumococcal (PCV)					
Meningococcal					
Hepatitis B					
Hepatitis A					
Varicella (Chicken pox)					
Human papillomavirus (HPV)					
Tuberculosis (Mantoux or PPD)					
Influenza (Flu)					
Tetanus (Td/TdaP)					
Other					

<b>Tests</b>	<b>Date</b>	<b>Results</b>	<b>Date</b>	<b>Results</b>	<b>Date</b>	<b>Results</b>
Lead test						
Other						
Other						

**Anything you would like to add?**

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**Which family members, guardians, or other people are allowed to discuss your child's medical information with your doctor? You'll need to include them on the "HIPAA" privacy form your doctor gives you.**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_