Emergency Information Form for Students with Special Needs

Last name:

Date form completed	**Revised**	**Initials**
By Whom	**Revised**	**Initials**

Name:	Birth date:	Nickname:
Home Address:	Home/Work Phone:	
Parent/Guardian:	Emergency Contact Names & Relationship:	
Signature/Consent*:		
Primary Language:	Phone Number(s):	
Physicians:		
Primary Care Physician:	Emergency Phone:	
	Fax:	
Current Specialty Physician:	Emergency Phone:	
Specialty:	Fax:	
Current Specialty Physician:	Emergency Phone:	
Specialty:	Fax:	
Anticipated Primary ED:	Pharmacy:	
Anticipated Tertiary Care Center:		

Diagnoses/Past Procedures/Physical Exam

1.	Baseline physical findings:
2.	
3.	Baseline vital signs:
Synopsis:	
	Baseline neurological status:
	Blood Type:

***Consent for release of this form to health care providers**

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American College of Emergency Physicians® American Academy of Pediatrics

Last name:

Diagnoses/Past Procedures/Physical Exam *(Continued)*

Medications/Dosages:		Significant baseline ancillary findings (lab, x-ray, ECG):
1.		
2.		
3.		Prostheses/Appliances/ Technology Devices:
4.		
5.		

Management Data:

Allergies: Medications/Foods to be avoided	and why:
1.	
2.	
3.	
Procedures to be avoided	**and why:**
1.	
2.	
3.	

Immunizations (mm/yy)

Dates						Dates					
DPT						Hep B					
OPV						Varicella					
MMR						TB status					
HIB						Other					

Antibiotic prophylaxis: Indication: Medication and dose:

Common Presenting Problems/Findings With Specific Suggested Managements

Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:

Physician/Provider Signature: Print Name:

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APPENDIX C

Laminate this card and affix it to a lanyard
for the special needs student to wear during an emergency.

Emergency Medical Information Card

Student Name:	Photo:
School: Grade : School Phone:	
Medical Condition:	
Parent/Guardian:	Home Phone:
Home Address:	Work Phone: Cell Phone:
Parent:/Guardian:	Home Phone:

Parents are responsible for updating the student's emergency information and medications.

FRONT

cut or fold here

BACK

Emergency Medical Information Card

Student Name:	Birth date:
Blood Type:	Allergies:
Physical Limitations:	
Communication Difficulties:	
Adaptive Equipment::	

Primary Care Physician:	Emergency Phone:
Specialty Physician:	Emergency Phone:
Insurance Company :	Policy Number:

Medications	Dosages/Frequency

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