Care Notebook

FOR ______________________

(Insert photo here)

Please return this CONFIDENTIAL Care Notebook to:

____

____

____

Care Notebook

Are you a parent of a child with special needs? This Care Notebook is a tool to help you organize and keep track of information about your child. This is your place to organize medical, educational, and other pertinent information.

You can personalize this Care Notebook to meet your needs. Uses include:

- Planning tool and time saver
- Everything in one place so information is at your fingertips
- Portable (take to school meeting, doctors' appointments, etc.)
- Helps you when advocating for your child
- Can help strengthen communication between your family and health and educational professionals

Vermont Family Network provides a range of programs and services for families and professionals across the state. Call us or visit our website for more information.

Support o **Information** o **Connections**

1-800-800-4005 or (802) 876-5315

VermontFamilyNetwork.org

Be social with us:
Facebook.com/VermontFamilyNetwork/
Twitter.com/VTFN

Check out our educational videos:
Youtube.com/user/vtfamilynetwork

Family Information

Child's Name ____________________

Date of Birth ____________ Social Security # ____________

Insurance Info ____________________

Diagnosis ____________________

Blood Type ____________________

Known Allergies ____________________

Primary Physician ____________ Phone ____________

Parent/Guardian:

Name/Address	
	Phone
	Office / Work hours:
	Fax
	Cell
	Email

Parent/Guardian:

Name/Address	
	Phone
	Office / Work hours:
	Fax
	Cell
	Email

Emergency Contact:

Name/Address	
	Phone
	Office / Work hours:
	Fax
	Cell
	Email

Sibling's Name ____________ Age ______

Sibling's Name ____________ Age ______

Sibling's Name ____________ Age ______

Sibling's Name ____________ Age ______

Sibling's Name ____________ Age ______

Sibling’s Name ______________________________ Age ______

Sibling’s Name ______________________________ Age ______

Sibling’s Name ______________________________ Age ______

Sibling’s Name ______________________________ Age ______

Sibling’s Name ______________________________ Age ______

Family Medical History

Name ____

Mother's Family

	Name	Date of Birth	Serious illness or other medical conditions of age at onset	If deceased list cause and age at death
Maternal Grandfather				
Sibling				
Sibling				
Sibling				

Maternal Grandmother				
Sibling				
Sibling				
Sibling				

Mother				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				

Father's Family

Paternal Grandfather				
Sibling				
Sibling				
Sibling				

	Name	Date of Birth	Serious illness or other medical conditions of age at onset	If deceased list cause and age at death

Father's Family (continued)

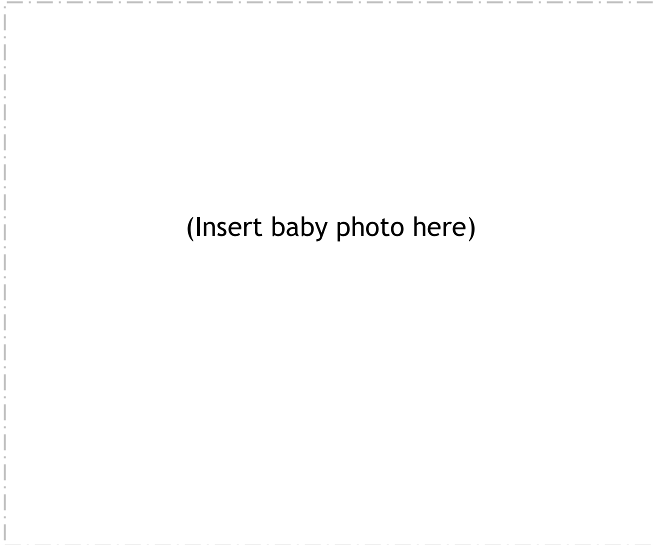
Paternal Grandmother				
Sibling				
Sibling				
Sibling				

Father				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				

Your Family

You				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				

Birth History


(Insert baby photo here)

Name:______________________________________

Birth Date:__________________________________

Birth Weight:__________lbs. _________ oz.

Length: ____________________________________

Was Baby full-term? YES NO

If no, weeks of gestation:_________________

APGAR: ___________1 min ______________5 min

Newborn Hearing Test: ☐ Passed ☐ Follow-up needed _______________ Date: _____________

Birth Hospital:____

How long was the baby hospitalized and where:

____

____

Primary Pediatrician in the hospital:

____

____

Baby's Condition at birth:

____

____

____

____

____

____

____

Favorite Things

Food	
Toys	
Books	
Friends	
Games	
Activities	
Colors	
Other	

Feeding And Nutrition History

When your baby came home from the hospital were they:

Breast Fed:______________ How long: ____

Bottle Fed:______________ What kind:____

Fed by other means (e.g. G-tube, etc.):

____

Did formula/feedings need to be changed:

____

At what age were solids started:

____

When did they go from bottle to cup:

____

Reactions to specific foods:

____

Nutritionist:

____

Additional Notes:

____

____

____

____

____

____

____

First Milestones

Month 1	
Month 2	
Month 3	
Month 4	
Month 5	
Month 6	
Month 7	
Month 8	
Month 9	
Month 10	
Month 11	
Month 12	

Development Record

Skill	List Dates/Age Child Mastered the Skill
Held up head	
Smiled	
Rolled over	
Sat without support	
Crawled	
Cruised (along furniture, etc.)	
Walked	
Used spoon/fork without spilling	
Spoke first word	
Spoke sentences	
Toilet Trained	Bladder: Bowel:
Any other milestones e.g. scribbling, writing, etc.	

Growth Tracking

Date	Height	Weight	%	Head Circumference	Checked By

All About Me! Section

The next few pages are examples of different tools you can use to share important information about your child. It may be helpful to share this information at school meetings, care conferences, doctors' appointments, with First Responders, Emergency Room personnel, or anyone else that your child will be in contact with. These tools are just ideas and can be modified to meet the needs of your child.

Things You Need To Know About My Child

Name they like to be called by:_______________________________________

My child likes it when you:

____

____

____

____

My child doesn't like it when you:

____

____

____

____

My child cooperates best when you:

____

____

____

____

Some of my child's favorite things are:

____

____

____

____

My child's biggest strengths are:

____

____

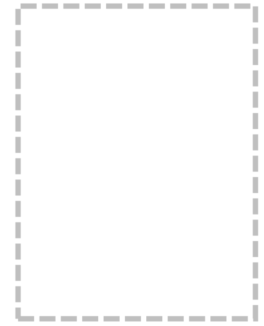
____

____

My One Page Profile

Your Name

Age



What people **appreciate** about me	What is **important** to me	How to **support** me

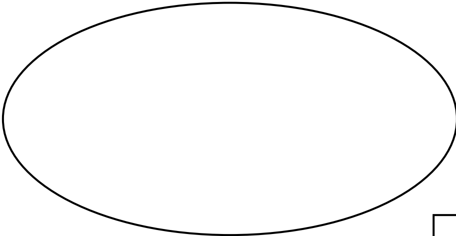
ECO MAP

Education

Support

Primary Family

Animals



Extended Family

Community

Other Services

Health Condition

Durable Medical Equipment

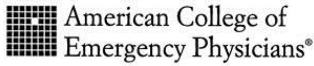
Medications

Other

Physicians

Emergency Information Form for Children With Special Needs

Last name:


American College of Emergency Physicians®

American Academy of Pediatrics

Date form completed By Whom	Revised	Initials
	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: Specialty:	Emergency Phone:
	Fax:
Current Specialty physician: Specialty:	Emergency Phone:
	Fax:
Anticipated Primary ED:	Pharmacy:
Anticipated Tertiary Care Center:	

Diagnoses/Past Procedures/Physical Exam:

1.	Baseline physical findings:
2.	
3.	Baseline vital signs:
4.	
Synopsis:	
	Baseline neurological status:

*Consent for release of this form to health care providers

Last name:

Diagnoses/Past Procedures/Physical Exam continued:

Medications:

1.

2.

3.

4.

5.

6.

Significant baseline ancillary findings (lab, x-ray, ECG):

Prostheses/Appliances/Advanced Technology Devices:

Management Data:

Allergies: Medications/Foods to be avoided **and why:**

1.

2.

3.

Procedures to be avoided **and why:**

1.

2.

3.

Immunizations

Dates					
DPT					
OPV					
MMR					
HIB					

Dates					
Hep B					
Varicella					
TB status					
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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Emergency Contacts

Name		Relationship	
Address		Work Phone	
		Home Phone	
		Cell Phone	

Name		Relationship	
Address		Work Phone	
		Home Phone	
		Cell Phone	

Name		Relationship	
Address		Work Phone	
		Home Phone	
		Cell Phone	

Name		Relationship	
Address		Work Phone	
		Home Phone	
		Cell Phone	

Name		Relationship	
Address		Work Phone	
		Home Phone	
		Cell Phone	

Name		Relationship	
Address		Work Phone	
		Home Phone	
		Cell Phone	

Emergency Room Information

Child's Name ______________________________________Date of Birth ______________
Social Security # ______________________
Parent / Guardian Name: ________________________ Home Phone: _________________
Home Address: ____

INSURANCE:

Insurance Company: __________________________ Policy Number: _________________
Policyholder's name: __________________________Group: ______________________
Medicaid Number: _________________________

DIAGNOSES:

____
____
____

MEDICATIONS:

Name of Medication	Strength (see label)	Dosage (amount)	Frequency	Time last given

ALLERGIES: ____

BASELINE DATA:

Pulse rate: _____________________________ Site best taken: __________________
Blood pressure: _________________________ Site best taken: __________________
Temperature: ______________________ Site best taken: __________________
Respiratory Rate: _________ per minute Oxygen Saturation: ____________
Skin color: ___________________________Best blood draw site:____________________
Pupils (normal, dilated, constricted, equal): ___________________________________

COMMUNICATION:

Preferred Method of Communication: __________________________ Language: ______________

How do I express pain? ____

Does anything in particular upset or over stimulate me? (Loud noises, bright lights, medical equipment, separation from you, touch) ____

What helps to calm or relax me? ____

Medical Contacts

Primary Physician

Name ____

Address____

____

Phone ______________________ Emergency # ________________

Hospital

Name ____

Contact ______________________ Phone ____________________

Address ____

____

Hospital

Name ____

Contact ______________________ Phone ____________________

Address ____

____

Specialist

Name ____

Address____

____

Phone ______________________ Emergency # ________________

Specialist

Name ____

Address____

____

Phone ______________________ Emergency # ________________

Specialist

Name ____

Address ____

____

Phone ______________________ Emergency # ______________________

Specialist

Name ____

Address ____

____

Phone ______________________ Emergency # ______________________

Dentist/Orthodontist

Name ____

Address ____

____

Phone ______________________ Emergency # ______________________

Pharmacy

Name ____

Contact ______________________ Phone ______________________

Address ____

____

Pharmacy

Name ____

Contact ______________________ Phone ______________________

Address ____

____

Early Intervention Services

Children's Integrated Services Early Intervention Program

Name ____________________

Address____________________

____

Phone ____________________

Email ____________________

Childcare Center

Name ____________________

Address____________________

____

Phone ____________________

Email ____________________

Early Childhood Special Education

Name ____________________

Address____________________

____

Phone ____________________

Email ____________________

Other

Name ____________________

Address____________________

____

Phone ____________________

Email ____________________

Therapists

Physical Therapist

Name ____________________

Organization ____________________

Address____________________

____

Phone ____________________ Email ____________________

Occupational Therapist

Name ____________________

Organization ____________________

Address____________________

____

Phone ____________________ Email ____________________

Speech/Language Therapist

Name ____________________

Organization ____________________

Address____________________

____

Phone ____________________ Email ____________________

Other

Name ____________________

Organization ____________________

Address____________________

____

Phone ____________________ Email ____________________

Other

Name ____

Organization ____

Address____

____

Phone ___________________________ Email _____________________________________

Other

Name ____

Organization ____

Address____

____

Phone ___________________________ Email _____________________________________

Other

Name ____

Organization ____

Address____

____

Phone ___________________________ Email _____________________________________

Other

Name ____

Organization ____

Address____

____

Phone ___________________________ Email _____________________________________

Additional Support Resources

Social Worker, Nurses Association, Counseling, Personal Care, Transportation, etc.

Vermont Family Network

VermontFamilyNetwork.org

Vermont Family Network
600 Blair Park Road, Suite 240
Williston,VT 05495
1-800-800-4005 or (802) 876-5315

info@vtfn.org or ____________________________@vtfn.org

Name ____

Organization ____

Address____

____

Phone ________________________ Email ____

Name ____

Organization ____

Address____

____

Phone ________________________ Email ____

Name ____

Organization ____

Address____

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Phone ________________________ Email ____

Name ____

Organization ____

Address____

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Phone ________________________ Email ____

Additional Support Resources

Name ____

Organization ____

Address____

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Phone _______________ Email ______________________________

Name ____

Organization ____

Address____

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Phone _______________ Email ______________________________

Name ____

Organization ____

Address____

____

Phone _______________ Email ______________________________

Name ____

Organization ____

Address____

____

Phone _______________ Email ______________________________

Name ____

Organization ____

Address____

____

Phone _______________ **Email** ______________________________

Medical History

Keeping records of your child's medical history is essential for such things as doctors' visits and school transfers. Use this table below to record illnesses, surgeries, vaccinations, hospitalizations, procedures, lab results and any other important medical information.

Illnesses

Illness	Date or Age	Description of Illness

Surgeries

Surgery	Date or Age	Description of Surgery

Vaccinations

Vaccination	Date or Age	What is this vaccination for?	Reaction?

Procedures

Procedure	Date or Age	What is the procedure for?	Complications?

Lab Results

Test	Date or Age	Results	Next Due

Allergies

Use this form to keep track of any allergies your child may have.
Be sure to include drug, food, fabric, animal, latex and plant allergies.

Allergy	Severity	Date of Onset	Symptom/Reaction

Supplies and Equipment

Provider Name & Address	Phone/Fax	Equipment Provided	Date

Medication Information

Medication:		Times taken a day		Dosage amount	
Special conditions for taking medication (with food)		Possible side effects		Who to call with concerns	

Medication:		Times taken a day		Dosage amount	
Special conditions for taking medication (with food)		Possible side effects		Who to call with concerns	

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Special conditions for taking medication (with food)		Possible side effects		Who to call with concerns	

Medication:		Times taken a day		Dosage amount	
Special conditions for taking medication (with food)		Possible side effects		Who to call with concerns	

Dental History

Date	Dentist	Problem / Treatment

Do you have latex allergy? ☐ Yes ☐ No

Please Describe: ____

____

____

____

____

____

School Contacts

School Name			
Phone #		Fax #	
Address			
Principal			
Teacher(s)			
Special Educator(s)			
Other IEP/Team Members (PT, OT, Speech, SpecEd)			
Guidance Counselor			
Nurse			
School Transportation			
District Special Education Coordinator			
Vermont Special Ed Tech Assistance Line			
Educational Support	Vermont Family Network info@ vtfn.org 1 800-800-4005 or (802) 876-5315 vermontfamilynetwork.org		

Other

____

____

____

____

____

____

Education Contact Log

Date:	Notes:	Follow up needed? ☐ YES ☐ NO
Contact name:		Action taken: ○ Letter sent on ______________ Meeting requested ☐ YES ☐ NO ○ Email sent on _______________ ○ Phone Call made on ____________ ○ Meeting date set for _____________ ○ Other ___________________________
Type of contact: ○ Letter ○ Email ○ Phone Call ○ In-Person		

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Contact name:		Action taken: ○ Letter sent on ______________ Meeting requested ☐ YES ☐ NO ○ Email sent on _______________ ○ Phone Call made on ____________ ○ Meeting date set for _____________ ○ Other ____________________________
Type of contact: ○ Letter ○ Email ○ Phone Call ○ In-Person		

Doctor Appointments

Doctor's Name:	Questions /Concerns to discuss:
Appointment Date	
Appointment Time	
Doctor's Name:	Questions /Concerns to discuss:
Appointment Date	
Appointment Time	
Doctor's Name:	Questions /Concerns to discuss:
Appointment Date	
Appointment Time	
Doctor's Name:	Questions /Concerns to discuss:
Appointment Date	
Appointment Time	
Doctor's Name:	Questions /Concerns to discuss:
Appointment Date	
Appointment Time	
Doctor's Name:	Questions /Concerns to discuss:
Appointment Date	
Appointment Time	

Doctor's Name:	Questions /Concerns to discuss:
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Doctor Appointments

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Place Your Calendars Here
For Upcoming Appointments

Insurance Information

Insurance Type	Address:	Current ☐ Yes ☐ No
Insurance Name:	Reason for Termination	Termination Date

Insurance Type	Address:	Current ☐ Yes ☐ No
Insurance Name:	Reason for Termination	Termination Date

Insurance Type	Address:	Current ☐ Yes ☐ No
Insurance Name:	Reason for Termination	Termination Date

Insurance Type	Address:	Current ☐ Yes ☐ No
Insurance Name:	Reason for Termination	Termination Date

Insurance Type	Address:	Current ☐ Yes ☐ No
Insurance Name:	Reason for Termination	Termination Date

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Insurance Name:	Reason for Termination	Termination Date