

Care Notebook

For	
(Insert photo here)	
Please return this CONFIDENTIAL Care Noteboo	ok 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	th Social Secur	
Insurance Info		
Diagnosis		
Blood Type		
Known Allergies		
Primary Physician		Phone
Parent/Guardian:		
Name/Address	Phone	
	Office	Work hours:
	Fax	
	Cell	
	Email	
Parent /Cuardian	·	
Parent/Guardian: Name/Address	Dhana	
raine, radi ess		Work
	Office _	hours:
	Fax _	
	Cell _	
	Email	
Emergency Contact:		
Name/Address	Phone	T
	Office	Work hours:
	Fax	,
	Cell	
	Email	
Sibling's Name		Age
Sibling's Name		
Sibling's Name		
Sibling's Name		
Sibling's Name		Age

Sibling's Name	Age
Sibling's Name	Age

Family Medical History

Name			<u> </u>	
Mother's Far	Name mily	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				
	Ī	1	T	T
Mother				
Sibling				
Father's Fan	nilv			
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 Fan	nily (continued)			
Paternal				
Grandmother				
Sibling				
Sibling				
Sibling				
Father				
Sibling				
Your Family				
You				
Sibling				

Birth History

	Name:
: ! !	Birth Date:
	Birth Weight:lbs oz.
(Insert baby photo here)	Length:
! ! :	Was Baby full-term? YES NO
	If no, weeks of gestation:
	APGAR:1 min5 min
Newborn Hearing Test: ☐ Passed ☐ Fo	ollow-up needed Date:
Birth Hospital:	
How long was the baby hospitalized and	d 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 hom	ne 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	I to be changed:	
At what age were solids sta	arted:	
When did they go from bot		
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	
	Bladder:
Toilet Trained	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 <u>doesn't</u> 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
appr	eciate
abo	ut me

What is important to me

How to support me

Education	Support	ECO MAP
	Primary Family	Animals
		Extended Family
Community	er Services	Health Condition
Durable Medical Equipm	I I	Medications
Other		Physicians

Emergency Information Form for Children With Special Needs

American College of
American College of Emergency Physicians

Name:

Home Address:

American Academy of Pediatrics



Date form
completed
By Whom

Birth date:

Revised Revised

Nickname:

Initials Initials

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:		
Diagraphy (Deat Drandures (Dhusia et France)		
Diagnoses/Past Procedures/Physical Exam:		
50 No. 10	Baseline physical findings:	
50 No. 10	Baseline physical findings:	
50 No. 10	Baseline physical findings:	
1. <u>E</u>	Baseline physical findings:	
1. E	Baseline physical findings: Baseline vital signs:	
1. E		
1. E		
1. 2. 3. 4.		
1. E	Baseline vital signs:	
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1. E	Baseline vital signs:	
1. E	Baseline vital signs:	

Significant baseline ancillary findings (lab, x-ray, ECG): Prostheses/Appliances/Advanced Technology Devices: and why: and why: Dates Hep B Varicella TB status	Prostheses/Appliances/Advanced Technology Devices: anagement Data: ergies: Medications/Foods to be avoided and why: anagement Data: and why: and why:	Medications: 1. 2. 3.				Significant baseling	ne ancillary findi	ng (lah y-ray	ECC).	
and why: and why: Dates Hep B Varicella	anagement Data: ergies: Medications/Foods to be avoided and why: decedures to be avoided and why: munizations tes Dates Hep B Hep B Varicella TB status Other BY Varice II TB status Other it ibiotic prophylaxis: Indication: Medication and dose:	2.						igo (lab, x ray,	cou).	
and why: and why: Dates Hep B Varicella	anagement Data: ergies: Medications/Foods to be avoided and why: decedures to be avoided and why: munizations tes Dates Hep B Hep B Varicella TB status Other BY Varice II TB status Other it ibiotic prophylaxis: Indication: Medication and dose:					CONTRACTOR OF THE RESIDENCE				
and why: and why: Dates Hep B Varicella	anagement Data: ergies: Medications/Foods to be avoided and why: decedures to be avoided and why: munizations tes Dates Hep B Hep B Varicella TB status Other BY Varice II TB status Other it ibiotic prophylaxis: Indication: Medication and dose:	3.								
and why: and why: Dates Hep B Varicella	anagement Data: ergies: Medications/Foods to be avoided and why: decedures to be avoided and why: munizations tes Dates Hep B Hep B Varicella TB status Other BY Varice II TB status Other it ibiotic prophylaxis: Indication: Medication and dose:	500A					1900 A. C.			
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and why: Dates Hep B Varicella	ergies: Medications/Foods to be avoided and why: cocedures to be avoided and why:	6.								
and why: Dates Hep B Varicella	munizations tes Dates Hep B Varicella TB status Dther Indication: Medication and dose:	Management Data:								
Dates Hep B Varicella	Dates		o be avoided		15-45-	and why:				
Dates Hep B Varicella	Dates	1.	***************************************	111111111111111111111111111111111111111						
Dates Hep B Varicella	Dates						2-11-12-23 - 1 - 13-12-23 	200		
Dates Hep B Varicella	Dates	2.						**************************************		
Dates Hep B Varicella	Dates	3.								
Hep B Varicella	Dates	Procedures to be avoided				and why:		1000 1000 1000 1000 1000 1000 1000 100		
Hep B Varicella	Dates	1.				****				
Hep B Varicella	Dates	2.								
Hep B Varicella	Dates	3.								
Hep B Varicella	Dates).								
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Varicella	V Varicella TB status Other Other Indication: Medication and dose:	Dates				Dates				
	TB status Other Indication: Medication and dose:	DPT								
	Other Indication: Medication and dose:									
[KNOC 1974-024-039]	ibiotic prophylaxis: Indication: Medication and dose:	HIB				CONTROL OF PERSONNEL				
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Other	emmon Presenting Problems/Findings With Specific Suggested	OPV MMR HIB Antibiotic prophylaxis:	oblems/Find		oteopie	Varicella TB status Other	 M			
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	Suggested Diagnostic Studies Treatment Considerations mments on child, family, or other specific medical issues:		P30 2513/41			19				
		1								
		Physician/Provider Signature:			200000124 (1000000011	Print Name:			region (Bellin) and That is proposition	

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	
Maria	Deletionship	
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	j:		Home Phone:	
Home Address:				
INSURANCE:				
Insurance Company:		Po	licy Number:	
Policyholder's name:		Gr	oup:	
Medicaid Number:				
DIAGNOSES:				
MEDICATIONS:				
Name of Medication	Strength (see label)	Dosage (amount)	Frequency	Time last given
ALLERGIES:			1	
BASELINE DATA:				
Pulse rate:		Site b	oest taken:	
Blood pressure:		Site b	oest taken:	
Temperature:		Site b	oest taken:	
Respiratory Rate:	per minute	0	xygen Saturation:	
Skin color:		Best blood dr	raw site:	
Pupils (normal, dilated,	constricted, equa	al):		

COMMUNICATION: Preferred Method of Communication: ______ Language: ______

equipment, separation from you, touch)

What helps to calm or relax me? _____

Medical Contacts

Primary Physician	
Name	
Address	
Phone	Emergency #
Hospital	
Name	
Contact	Phone
Hospital	
Contact	Phone
Specialist	
Address	
Phone	Emergency #
Specialist	
Name	
Address	
Phone	Emergency #

Name	
Address	
Phone	Emergency #
cialist	
Name	
Address	
Phone	Emergency #
tist/Orthodontist	
Name	
Address	
	Emergency #
rmacy	
Contact	Phone
Address	
rmacy	
	Phone
Contact	

Early Intervention Services

	grated Services E		<u>J</u>	
Name				
Address				
Phone				
Email				
dcare Cent				
Address				
Phone				
Email				
y Childhood	Special Educatio	on		
Name				
Address				
Phone				
Email				
Email				
Email				
er Name				
Email Phone				

Therapists

Physical Therapist Name		
Organization		
Address		
Phone	Email	
Occupational Therap	ist	
Name		
Organization		
Address		
Phone	Email	
Speech/Language Th	erapist	
Name		
Organization		
Address		
Phone	Email	
Other		
Name		
Organization		
Address		
Phone	Email	

Oth	er			
	Name		 	
	Organization		 	
	Phone	Email		
Oth	er			
	Name			
	Phone	Email		
Oth	er			
	Name		 	
	Organization			
	Address			
	Phone	Email		
Oth	er			
	Name			
	Organization			
	Addi C33			
	Phone	Email		

Additional Support Resources

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



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 _____ Organization _____ Phone Email Organization _____ Address Phone _____ Email _____ Address_____ Phone _____ Email _____

Additional Support Resources

Name		_
Organization		-
Address		
		_
Phone	Email	_
Name		_
Organization		-
Address		
		_
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
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	
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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 lat	ex allergy? □ Yes □ No	
Please Describe	::	

School Contacts

School Name		1 1	
Phone #		Fax #	
Address			
Principal			
Teacher(s)			
Special Educa	tor(s)		
Other IEP/Tea (PT, OT, Spee			
Guidance Cou	nselor		
Nurse			
School Transp	ortation		
District Specia Education Cod	nl ordinator		
Vermont Spec Assistance Lin			
Educational Su	upport	Vermont Family Network info@ vtfn.org 1 800-800-4005 or (802) 876-5315 vermontfamilynetwork.org	
er			

Education Contact Log

Date:	Notes:	Follow up needed? YES NO
Contact name:		Action taken: o Letter sent on
Type of contact:	Notes:	Meeting requested ☐ YES ☐ NO ○ Email sent on ○ Phone Call made on ○ Meeting date set for ○ Other Follow up needed? ☐ YES ☐ NO Action taken: ○ Letter sent on Meeting requested ☐ YES ☐ NO ○ Email sent on ○ Phone Call made on ○ Meeting date set for ○ Other
		o Other
Date:	Notes:	Follow up needed? ☐ YES ☐ NO
Contact name:		Action taken: o Letter sent on
Type of contact:		Meeting requested ☐ YES ☐ NO ○ Email sent on ○ Phone Call made on ○ Meeting date set for ○ Other
Date:	Notes:	Follow up needed? ☐ YES ☐ NO
Contact name:		Action taken: o Letter sent on
Type of contact:		Meeting requested ☐ YES ☐ NO ○ Email sent on ○ Phone Call made on ○ Meeting date set for ○ Other

Date:	Notes:	Follow up needed? ☐ YES ☐ NO
Contact name:		Action taken: o Letter sent on
Type of contact: o Letter o Email		Meeting requested ☐ YES ☐ NO ○ Email sent on
Phone Call		o Phone Call made on
In-Person		Meeting date set for
		o Other
Date:	Notes:	Follow up needed? ☐ YES ☐ NO
	Notes.	
Contact name:		Action taken: o Letter sent on
Type of contact:		Meeting requested ☐ YES ☐ NO
○ Letter○ Email		o Email sent on
Phone Call		o Phone Call made on
o In-Person		o Meeting date set for
		o Other
Date	Notes:	Follow up needed? TYES TINO
Date:	Notes:	Follow up needed? ☐ YES ☐ NO
Date: Contact name:	Notes:	Follow up needed? YES NO Action taken: Letter sent on
Contact name: Type of contact:	Notes:	Action taken:
Contact name: Type of contact: • Letter	Notes:	Action taken: o Letter sent on
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Contact name: Type of contact:	Notes:	Action taken: o Letter sent on Meeting requested □ YES □ NO o Email sent on
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Education Contact Log

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

Date:	Notes:	Follow up needed? ☐ YES ☐ NO
Type of contact: Letter Email Phone Call In-Person		Action taken: Letter sent on Meeting requested □ YES □ NO Email sent on Phone Call made on Meeting date set for Other
Date:	Notes:	Follow up needed? ☐ YES ☐ NO
Type of contact: o Letter o Email o Phone Call o In-Person		Action taken: Letter sent on Meeting requested □ YES □ NO Email sent on Phone Call made on Meeting date set for Other
Date:	Notes:	Follow up needed? ☐ YES ☐ NO
Contact name:	Notes.	Action taken: o Letter sent on
Type of contact:		Meeting requested ☐ YES ☐ NO ○ Email sent on ○ Phone Call made on ○ Meeting date set for ○ Other
Date:	Notes:	Follow up needed? ☐ YES ☐ NO
Type of contact: Letter Email Phone Call In-Person		Action taken: • Letter sent on Meeting requested □ YES □ NO • Email sent on • Phone Call made on • Meeting date set for
		o Other

Education Contact Log

Date:	Notes:	Follow up needed? ☐ YES ☐ NO
Contact name:		Action taken: o Letter sent on
Type of contact: o Letter o Email		Meeting requested □ YES □ NO ○ Email sent on
Phone Call		o Phone Call made on
o In-Person		o Meeting date set for
		o Other
Date:	Notes:	Follow up needed? ☐ YES ☐ NO
	Tiotes.	
Contact name:		Action taken: o Letter sent on
Type of contact:		Meeting requested ☐ YES ☐ NO
LetterEmail		o Email sent on
Phone Call		o Phone Call made on
o In-Person		o Meeting date set for
<u></u>		o Other
Data	Notor	Follow up poodod? □ VES □ NO
Date:	Notes:	Follow up needed? ☐ YES ☐ NO
Date: Contact name:	Notes:	Follow up needed? YES NO Action taken: Letter sent on
Contact name: Type of contact:	Notes:	Action taken:
Contact name: Type of contact: Letter	Notes:	Action taken: o Letter sent on
Contact name: Type of contact: Letter	Notes:	Action taken: ○ Letter sent on Meeting requested □ YES □ NO
Contact name: Type of contact: Letter Email	Notes:	Action taken: ○ Letter sent on Meeting requested □ YES □ NO ○ Email sent on
Contact name: Type of contact:	Notes:	Action taken: Letter sent on Meeting requested □ YES □ NO Email sent on Phone Call made on
Contact name: Type of contact: Letter Email Phone Call In-Person		Action taken: Letter sent on Meeting requested □ YES □ NO Email sent on Phone Call made on Meeting date set for Other
Contact name: Type of contact:	Notes:	Action taken: Letter sent on Meeting requested □ YES □ NO Email sent on Phone Call made on Meeting date set for Other Follow up needed? □ YES □ NO
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Place Your Calendars Here For Upcoming Appointments

Insurance Information

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Insurance Name:	Reason for Termination	Termination Date
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Insurance Name:	Reason for Termination	Termination Date
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Insurance Name:	Reason for Termination	Termination Date
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