Vermont Family Network

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				

Father's Family (continued)

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

Physicians

Other

Emergency Information Form for Children With Special Needs

Last name:

American College of Emergency Physicians®

American Academy of Pediatrics

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:

4.

Synopsis:

Baseline neurological status:

*Consent for release of this form to health care providers

Last name:

Diagnoses/Past Procedures/Physical Exam continued:

Medications:	Significant baseline ancillary findings (lab, x-ray, ECG):
1.	
2.	
3.	
4.	Prostheses/Appliances/Advanced Technology Devices:
5.	
6.	

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:**

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_____

_____

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	

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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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Type of contact: ○ Letter ○ Email ○ Phone Call ○ In-Person		

Doctor Appointments

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

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Doctor Appointments

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