In Case of Emergency

Child's name: ______________________________ Today's Date: _____________

Nickname:		Birth date:
Primary language/communication mode:		
Home address:		
Secondary address:		
Parent/Caregiver:	Relationship:	Phone:
Parent/Caregiver:	Relationship:	Phone:
Emergency Contact:	Relationship:	Phone:
Emergency Contact:	Relationship:	Phone:
Diagnosis:		
Allergies or dietary restrictions:		
Relevant health history: (recent surgery, current status)		

Medications	Dose/Time

Medical records are on file at:
Phone:
Fax:

Hospital Information		
Preferred hospital: **Address:**		**Phone:** **ED phone:**
Secondary hospital: **Address:**		**Phone:** **ED phone:**
Physician Information		
Doctor to call in an emergency:	**Phone:**	**Fax:**
Primary care doctor:	**Phone:**	**Fax:**
Specialist:	**Phone:**	**Fax:**
Specialist:	**Phone:**	**Fax:**
Specialist:	**Phone:**	**Fax:**
Preferred Pharmacy		
Name:	**Phone:**	**Fax:**
Insurance Information		
Insurance provider:	**ID#:**	**Phone:**
Important baseline health information: (vitals, neurologic or cognitive function)		
My equipment and assistive technology: (braces/orthotics, walker, wheelchair, communication devices, home O_2, insulin pump, suction)		
Most important things to know about me in an emergency: (fears, behaviors)		
Things that calm me down when I am scared or in pain: (distractions, songs, books, toys, breathing exercises)		

This form is available at www.cshcn.org/planning-record-keeping/documents/

Center for Children with Special Needs
www.cshcn.org

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