

# 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  
Revised

Initials  
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



[www.escapesafe.org](http://www.escapesafe.org)

For additional information or questions contact:  
Community Education and Child Advocacy Department  
1-888-365-2022

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					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:**

