

A PARENT'S NOTEBOOK:

ALL ABOUT MY CHILD



DEVELOPED BY:

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ABOUT MY CHILD



Name _____ Birth Date _____

Parent/guardian _____

Address _____

Phone Numbers: Home _____ Work _____

Emergency contact: Name _____ Phone # _____

Relationship _____

Insurance Information:

Medicaid # _____

Primary _____ Subscriber# _____ Group# _____

Secondary _____ Subscriber# _____ Group# _____

Primary Care Physician: _____ Phone # _____

Specialty Care Physicians:

Name _____ Phone # _____

Name _____ Phone # _____

Name _____ Phone # _____

Name _____ Phone # _____

Name _____ Phone # _____

School Information:

Name of school _____ Phone# _____

Contact name _____ Teacher _____

Pharmacy used for prescriptions _____

Phone # _____

MEDICAL HISTORY

Birth History:

Birth Weight _____ full term ___ premature ___ weeks gestation _____

Nursery Course _____

Allergies:

Special Diet/Nutritional Needs:

Special equipment/supply needs:

Type _____ Supplier _____

Type _____ Supplier _____

Type _____ Supplier _____

Type _____ Supplier _____

Surgical History:

Procedure _____ Date _____

MD/Facility _____

Procedure _____ Date _____

MD/Facility _____

Procedure _____ Date _____

MD/Facility _____

Procedure _____ Date _____

MD/Facility _____

Past Medical History:

Developmental History:



THINGS YOU NEED TO KNOW ABOUT MY CHILD

Name he/she likes 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 things that my child likes are:



EMERGENCY ROOM VISITS/HOSPITALIZATIONS

DATE	REASON	OUTCOME



ABOUT MY CHILD - A NOTEBOOK FOR PARENTS

Dear Parent(s),

This notebook is for you and your child. It will serve as a care plan for all your child's medical providers, help you keep your child's medical information up to date, and assist you in keeping up with the different people involved in your child's care. It will also help your child receive the best care from those who are providing the services.

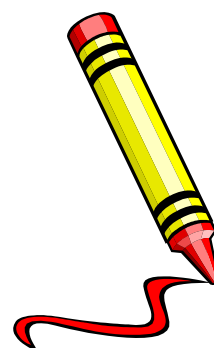
In order for this book to be helpful to you and your child's health care providers, please remember to:

1. take the book to the health care providers your child sees - even those that are not seen on a regular basis such as the emergency room or urgent care center.
2. ask your health care providers to log in each time you visit them or they visit your child at home.
3. sometimes remind the providers to update the book as things change for your child.
4. use the book to help you review your child's health care with any health care provider who is not familiar with your child.
5. use the book to write down any concerns you or your child may have before seeing your doctor or other health care provider.

The book is divided into tabbed sections with a list of what is in each section. Please take time to review each section and ask your primary care provider if you have any questions.

We are all partners in helping you care for your child and look forward to working with you.

Your care team



QUESTIONS/ CONCERNS/OUTCOME

DATE _____ CONCERN _____

OUTCOME _____

DATE _____ CONCERN _____

OUTCOME _____

DATE _____ CONCERN _____

OUTCOME _____

DATE _____ CONCERN _____

OUTCOME _____

DATE _____ CONCERN _____

OUTCOME _____

DATE _____ CONCERN _____

OUTCOME _____

DATE _____ CONCERN _____

OUTCOME _____



MEDICAL INFORMATION

This section contains my child's:

- ◆ medical history (basic medical information)
- ◆ problem list (active care plan)
- ◆ nutrition information (special nutritional needs)
- ◆ height and weight chart (a continuous record)
- ◆ immunization record (a continuous record)
- ◆ medication list (all current and discontinued medications)
- ◆ tests/x-rays/labs (a continuous record)



****** Make sure your care providers update this information at each visit. This information will be a continuous record of your child's medical care.

IMPORTANT INFORMATION ABOUT MY CHILD

This section contains:

- ◆ general information about my child (includes address, phone numbers, emergency contact information, health care providers)
- ◆ a list of my case managers/care coordinators/therapists
- ◆ things you should know about my child (what my child likes and doesn't like from people who help take care of him/her)
- ◆ a signed case management contract (tells me what my child's case manager will do, what my health care provider will do and what I will do to get the best care for my child)



SCHOOL INFORMATION

This section contains:

- ◆ any information I would like to keep that relates to my child's school experiences.



OTHER INFORMATION

This section contains:

- ◆ a question and concern form (will help me remember what I need to ask any of my child's care providers)
- ◆ an emergency room and hospitalization form (to keep information about any of these visits to share with my child's health care providers)
- ◆ a copy of important legal papers such as custody; guardianship; or advanced directives forms



COMMUNITY RESOURCES

This section contains:

- ◆ a list of community resources with phone numbers that may be helpful
- ◆ agency or program information you want to keep in one place
- ◆ a blank telephone list for important phone numbers



SIGN-IN LOG

This section contains:

- ◆ a sign-in log of all providers that have contact with my child and the result of that contact
(*it is very important to have all providers document in this section each time they visit with your child regardless of where that visit occurs)



TREATMENT PLANS

This section contains:

- ◆ any treatment plan that may be used to provide services to my child. This may include:
 - a care plan from the doctor
 - an IFSP (individual family service plan)
 - an IEP (individual education plan)
 - a speech, physical or occupational therapy plan
 - a psychosocial counseling or treatment care plan

(**remind your child's care providers to update these as things change.)



IMPORTANT PHONE NUMBERS

NAME: _____ TITLE: _____
PHONE:(h) _____ (w) _____

NAME: _____ TITLE: _____
PHONE:(h) _____ (w) _____

NAME: _____ TITLE: _____
PHONE:(h) _____ (w) _____

NAME: _____ TITLE: _____
PHONE:(h) _____ (w) _____

NAME: _____ TITLE: _____
PHONE:(h) _____ (w) _____

NAME: _____ TITLE: _____
PHONE:(h) _____ (w) _____

NAME: _____ TITLE: _____
PHONE:(h) _____ (w) _____

NAME: _____ TITLE: _____
PHONE:(h) _____ (w) _____



IMMUNIZATIONS

Vaccination	Administration date	Age
DTP/DtaP ₁		
DTP/DtaP ₂		
DTP/DtaP ₃		
DTP/DtaP ₄		
DTP/DtaP ₅		
DT		
Td		
OPV/IPV ₁		
OPV/IPV ₂		
OPV/IPV ₃		
OPV/IPV ₄		
MMR ₁		
MMR ₂		
HIB Titer 1		
HIB Titer 2		
HIB Titer 3		
HIB Titer 4		
HEP B 1		
HEP B 2		
HEP B 3		
Varivax		
Rota Shield 1		
Rota Shield 2		
Rota Shield 3		
Prevnar 1		
Prevnar 2		
Prevnar 3		
Prevnar 4		



**MY CHILD'S
CASE MANAGERS/CARE COORDINATORS/THERAPISTS**

LEAD CASE MANAGER OR CARE COORDINATOR

NAME _____

AGENCY _____

CONTACT PHONE # _____

OTHER CASE MANAGERS/CARE COORDINATORS/THERAPISTS

NAME _____

AGENCY _____

CONTACT PHONE # _____

NAME _____

AGENCY _____

CONTACT PHONE # _____

NAME _____

AGENCY _____

CONTACT PHONE # _____

NAME _____

AGENCY _____

CONTACT PHONE # _____

