All About My Child

- **Quick Reference**
  - Child's Home Address
  - Primary Care Doctor/Medical Home Provider
  - Urgent Care/After Hours/Advice Nurse
  - Family Contact Information
  - Allergies
  - Insurance Information

- **Important Contact Information**

- **My Child's Care Coordinators**

- **All About My Child**

- **Things You Need to Know to Support Them**

- **My Child's Birth Story**

QUICK REFERENCE

Child's Name: Child's DOB:

Child's Home Address:

Primary Care Doctor/Medical Home Provider

Name: After hours Phone:

Phone Number: Fax:

Urgent Care - After Hours - Advice Nurse

Name:

Phone:

Family Contact Information

Name/Relation to child: Work Phone:

Home Phone: Cell Phone:

Name/Relation to child: Work Phone:

Home Phone: Cell Phone:

Emergency Contact: Relationship:

Home Phone: Work Phone:

Cell Phone:

Allergies

Food, Medication, etc.:

Insurance Information

Insurance: Policy #:

Phone: Subscriber #:

Fax #: Contact Person:

Insurance: Policy #:

Phone: Subscriber #:

Fax #: Contact Person:

IMPORTANT CONTACT INFORMATION

Life-Threatening Emergency: Call 911 or 988

Primary Care Doctor - Medical Home

Name:

Address:

City: Zip:

Care Coordinator:

Phone: Fax:

Hours: Email:

Urgent Care - After Hours - Advice Nurse

Name:

Address:

City: Zip:

Phone: Fax:

Hours: Email:

Primary Hospital

Hospital:

Information Phone Number:

Address:

Emergency Room Phone Number:

Special Transportation

Transportation Agency:

Contact Name: Phone:

Address:

Transportation Agency:

Contact Name: Phone:

Address:

*Child has a medical alert bracelet for:

Medical Equipment Supplier

Supplier: Product:

Contact: Phone:

Address: Fax:

Hours: Email:

Notes:

Community Agencies

Agency: Service:

Contact: Phone:

Address: Fax:

Hours: Email:

Agency: Service:

Contact: Phone:

Address: Fax:

Hours: Email:

Home Nursing Agencies

Agency: Service:

Contact: Phone:

Address: Fax:

Hours: Email:

Notes:

Agency: Service:

Contact: Phone:

Address: Fax:

Hours: Email:

Notes:

Infant Program - Preschool - School

School: Teacher:

Address: Phone:

Notes: Email:

School: Teacher:

Address: Phone:

Notes: Email:

Child Care Provider

Name: Phone:

Address: Email:

Notes:

Name: Phone:

Address: Email:

Notes:

Respite Care Provider

Name: Phone:

Address: Email:

School Nurse

Name: Phone:

Address: Email:

Notes:

Dentist - Orthodontist

Name: Phone:

Address: Fax:

Hours: Email:

Notes:

Social Worker

Name: Phone:

Address: Email:

Notes:

Specialist Doctors - Therapists - Other Care Providers

Provider: Specialty:

Clinic: Phone:

Address: Fax:

Hours::: Email:

Provider: Specialty:

Clinic: Phone:

Address: Fax:

Hours: Email:

Provider: Specialty:

Clinic: Phone:

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Provider: Specialty:

Clinic: Phone:

Address: Fax:

Hours: Email:

Pharmacy Used for Prescriptions

Pharmacy: Product:

Pharmacist: Phone:

Address: Fax:

Hours: Email:

Pharmacy: Product:

Pharmacist: Phone:

Address: Fax:

Hours: Email:

Public Health Department - Nurse

Name: Phone:

Address: Email:

Nutritionist

Name: Phone:

Address: Email:

Other

Name: Phone:

Title/Agency: Notes:

Name: Phone:

Title/Agency: Notes:

Name: Phone:

Title/Agency: Notes:

Name: Phone:

Title/Agency: Notes:

Name: Phone:

Title/Agency: Notes:

Public Health Department - Nurse

Name: Phone:

Address: Email:

Nutritionist

Name: Phone:

Address: Email:

Other

Name: Phone:

Title/Agency: Notes:

Name: Phone:

Title/Agency: Notes:

Name: Phone:

Title/Agency: Notes:

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Title/Agency: Notes:

Name: Phone:

Title/Agency: Notes:

Name: Phone:

Title/Agency: Notes:

MY CHILD'S
CARE COORDINATORS

Agency:

Care Coordinator: Phone:

Address: Fax:

City: Zip:

Notes:

Agency:

Care Coordinator: Phone:

Address: Fax:

City: Zip:

Notes:

Agency:

Care Coordinator: Phone:

Address: Fax:

City: Zip:

Notes:

Agency:

Care Coordinator: Phone:

Address: Fax:

City: Zip:

Notes:

All About My Child

My Child's Family

Parents/Caregivers:

Sibling(s):

Other people who live with us:

Pet(s):

My Child's Favorite:

Color:

Animal:

Activity:

Food:

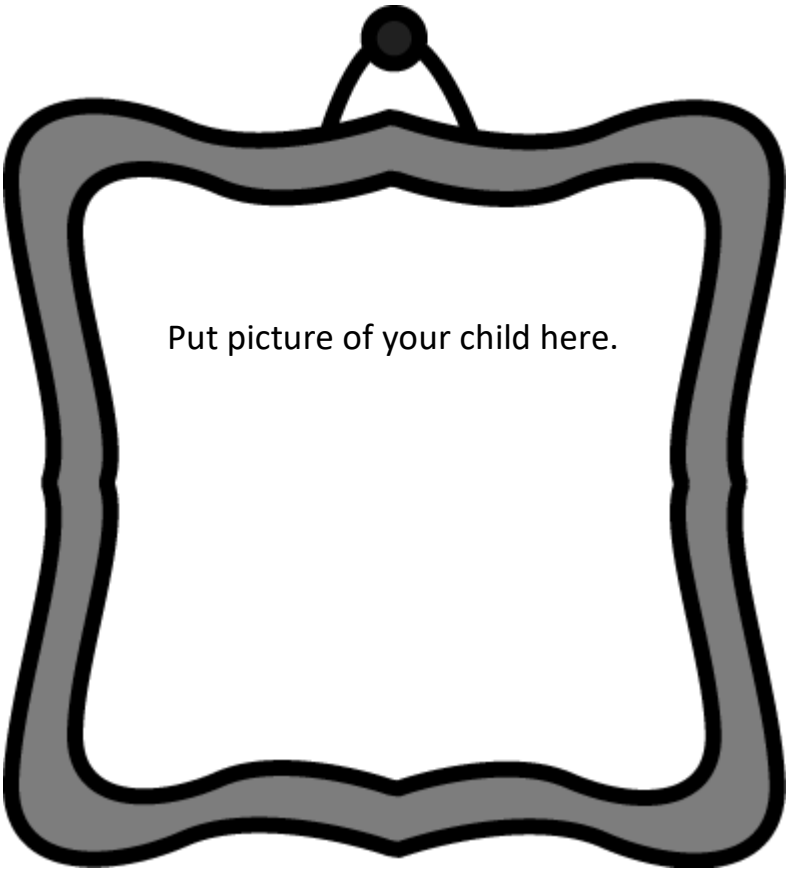
Book:

Movie:

Character:

Song:

Things to do:



THINGS YOU NEED TO KNOW
ABOUT MY CHILD TO SUPPORT THEM

Child's Full Name: _____ **Date of Birth:** _____

Name Child Prefers: _____ **Allergies:** _____

Child Communicates Using: (e.g. speech, preferred language, sign language, communication device, etc.)

Things My Child Does Well/Strengths: (e.g. dresses by self, is polite, loves to read, is very affectionate)

Things My Child Likes: (e.g. our pet, music, fresh air, high fives)

Things My Child is Working On: (e.g. expressing emotions, advocating for themselves, eye contact)

Things That Upset My Child: (e.g. loud noises, bright lights, textures/fabrics, waiting a long time)

When my child gets dressed, you may assist by:

When my child eats or drinks, you may assist by:

When my child takes their medication, they prefer to: (e.g. take with food, water, etc.)

My child's mobility needs are: (e.g. can transfer independently, needs help getting in car, needs additional time)

Other behaviors to be aware of: (e.g. sometimes runs away, talks to strangers, pulls hair when upset)

MY CHILD'S BIRTH STORY

Date of birth: