How can I organize my child's health information?

Use this care organizer to store your child's information. It can help you:

- Keep track of medicines, treatment and your child's health history
- Organize contact information for health care providers and community organizations
- Prepare for appointments

How do I get started?

- Gather existing information such as discharge reports, clinic visit summaries, immunization records, school plan, test results and care plans.
- Bring the organizer to appointments and meetings to share information and keep track of new information you are given.
- Take photos of forms you use often like the portable health history and keep a copy on your mobile phone.
- You can download electronic versions of these pages at **www.cshcn.org/planning-record-keeping/care-notebook**
- Order an accordion style file organizer from www.cshcn.org or store these pages in a binder, box, or whatever works best for you.
- **For more information or help with electronic forms call 206 987-3736, or visit www.cshcn.org.**

Center for Children with Special Needs, Seattle Children's
www.cshcn.org
Washington State Department of Health, Children with Special Health Care Needs Program

Seattle Children's HOSPITAL • RESEARCH • FOUNDATION
Center for Children with Special Needs www.cshcn.org
Washington State Department of Health

Tools and Forms for managing your child's care

Contents:

Contact Information

- Health care provider contact list
- Hospital & clinic information
- Pharmacy contacts
- Childcare, respite and babysitter

Tracking Tools

- Portable medical summary
- Appointment log
- Hospital stays tracking form
- Immunization record
- Care schedule
- Allergy log
- Lab work, tests and procedures
- Event and behavior log
- Growth tracking form
- Diet tracking form
- My child's development history
- Call log

Medication

- Medications list
- Daily medication tracking sheet

Support Resources

- Family support resources

School

- School, preschool and developmental center contacts

Equipment and Supplies

- Equipment and supplies list

Financial

- Insurance funding sources
- Out-of-pocket expense log

Emergency

- In case of emergency form

Portable Medical Summary

Tips: Keep laminated copies with you. You can also take a picture and keep copies on your mobile devices.

Child's Name:		
Date of birth:		
Age:	**Height:**	**Weight:**
Address and Contact Information		
Parents/Guardians:		**Relationship:**
Street:	**City:**	**State/zip:**
Home phone #s:		**Cell phone #s:**
Primary language/Communication:		
Important things to know about me:		

Medical Information	
Diagnosis(es):	**Age at time of diagnosis:**
1.	
2.	
3.	

Medications	Dose	Time	OTC Medications/Supplements:

Hospitalizations/Surgeries/Procedures:	Date	Hospital	Doctor

Portable Medical Summary

Allergies/Sensitivities	Reaction	Allergies/Sensitivities	Reaction

Healthcare and Other Providers	
Primary care provider:	Phone: Fax:
Specialty provider:	Phone: Fax:
Other provider:	Phone: Fax:
Other provider:	Phone: Fax:
Other Provider:	Phone: Fax:

Medical Equipment	Medical Supplies	Provider	Contact Info

Nutrition	Provider	Contact info

Immunization History			
Influenza (last) date:	Hepatitis B date(s):	MMR date(s):	Meningococcus date(s):
Td or Tdap date(s):	Hepatitis A date(s) :	Varicella date(s):	Polio date(s):
PPD date(s) :	Pneumovax date(s):	HPV date(s):	

Health Insurance	
Name: Group #: ID #: Phone: Fax:	Name: Group #: ID #: Phone: Fax:

Other important information:

Portable Medical Summary
Getting to Know Me

Tips: Use this to share information with your child's child care provider, therapists, camp counselors and others.

My Name:	**Nickname:**
Date of Birth:	**Today's Date:**
A Little About Me:	
My Strengths: (things that are easy for me)	
My Challenges: (communication, feeding, learning, mobility, social, energy, behavior)	
My Life in the Community: (school, childcare, place of worship, my favorite places)	
Ways You Can be Helpful to Me:	
Things to Avoid: (food, activities, and procedures)	
My Equipment/Assistive Technology:	
Other:	

Appointment Log

Tip: You can use the Evernote™ app to remind you when to make future appointments.

Use this form to keep track of your appointments and when to schedule future appointments.

Date	Provider or clinic seen	Reason seen/care provided	Next appointment (or when to schedule next appointment)	Clinic phone #
Example 2/7/15	Neurology, Dr. Roza	EEG. Went over seizure and sleep tracking sheets	Call in May to schedule next appointment	206 987-2201

Out-of-Pocket Expense Log

Use this log to track expenses that are not covered by insurance. Save receipts for tax purposes.

Date	Item	Cost

In Case of Emergency

Today's Date: _____

Your Name:	**Nickname:**	
Birth Date:	**Primary Language/Communication:**	
Home Address:		
Parents/Guardians:	**Relationship:**	**Home #:** **Other #'s:**
Diagnosis:		

Medications	Dose	Time

Allergies:		
Emergency Contact:	**Relationship:**	**Phone #'s:**

PHYSICIAN INFORMATION

Primary Doctor:	**Phone:**	**Fax:**
Specialist:	**Phone:**	**Fax:**
Specialist:	**Phone:**	**Fax:**
Insurance:		

HOSPITAL INFORMATION

Name: **Address:**	**Phone:** **ER Phone:**

PHARMACY INFORMATION

Name: **Address:**	**Phone:**

OTHER

Most Important Things to Know About Me in an Emergency:

Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION

Center for Children with Special Needs
www.cshcn.org

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Washington State Department of Health

Center 2008

Health Care Providers

Tip: Tape business cards on this page from the different providers your child sees.

List contact information for different providers your child sees including: doctors, specialists, OT/PT, speech and language therapists, dietitians, etc.

Care Provider:	
Name:	
Phone:	
Fax:	
Start date:	
End date:	
Address:	
E-mail:	
Website:	

Care Provider:	
Name:	
Phone:	
Fax:	
Start date:	
End date:	
Address:	
E-mail:	
Website:	

Care Provider:	
Name:	
Phone:	
Fax:	
Start date:	
End date:	
Address:	
E-mail:	
Website:	

Care Provider:	
Name:	
Phone:	
Fax:	
Start date:	
End date:	
Address:	
E-mail:	
Website:	

Hospital and Clinic Information

Tip: Your local hospital social media accounts will often have real-time hospital updates that may be good to keep note of.

Medical Record Number: _____

Local Hospital Address:

_____

City, State, Zip Code: _____

Website: _____

Phone Numbers

Main Number: _____ Emergency Room: _____

Twitter Account: _____ Facebook Account: _____

Specialty Clinic Name:	
Hours/Days of Operation:	
Physician:	
Contact Person (Nurse, doctor, receptionist):	
Phone:	
Email:	
Fax:	

Specialty Clinic Name:	
Hours/Days of Operation:	
Physician	
Contact Person (Nurse, doctor, receptionist):	
Phone:	
Email:	
Fax:	

Continued on next page...

Pharmacy Contact Information

Pharmacy:	
Hours/Days Open:	
Drive thru?	
Address:	
Phone:	
Fax:	
E-mail:	
Website:	

Pharmacy:	
Hours/Days Open:	
Drive thru?	
Address:	
Phone:	
Fax:	
E-mail:	
Website	

Pharmacy:	
Hours/Days Open:	
Drive thru?	
Address:	
Phone:	
Fax:	
E-mail:	
Website:	

Pharmacy:	
Hours/Days Open:	
Drive thru?	
Address:	
Phone:	
Fax:	
E-mail:	
Website:	

Childcare Respite and Babysitter Contacts

Childcare provider:	
Phone:	
Fax:	
Address:	
Email:	

Childcare provider:	
Phone:	
Fax:	
Address:	
Email:	

Respite care provider:	
Contact person:	
Address:	
Phone:	
Fax:	
Email:	

Respite care provider:	
Contact person:	
Address:	
Phone:	
Fax:	
Email:	

Babysitter:	
Address:	
Phone:	
Fax:	
Email:	
Other (days available, cost, etc.):	

Hospital Stays Tracking Form

Date	Hospital or Emergency Room	Reason	Notes
Example: 3/15-3/20/15	*ICU, then moved to floor*	*Respiratory infection*	*Dr. Walls talked with us about new treatment plan. We will discuss at our clinic appointment*

Immunization Record

LAST NAME	FIRST NAME	M.I.

BIRTHDATE (mm/dd/yy)

MEDICAL NOTES (allergies, vaccine reactions, etc.)

Vaccine	Type	Date Given (m/d/yy)	Administered By (clinic, doctor, etc)	Next Dose Date
Hepatitis B (HepB, Hib-HepB, HepA-HepB, DTaP-HepB-IPV)				
Diptheria, Tetanus, Pertussis (DTaP, DTP, DT, Td, Tdap, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, DTaP/Hib) boosters				
***Haemophilus Influenzae* type b** (Hib, Hib-HepB, DTaP-IPV/Hib, DTaP/Hib)				
Pneumococcal (PCV7, PCV13, PPSV23)				
Polio (IPV, OPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)				
Rotavirus (RV1, RV5, RV [unknown])				
Measles, Mumps, & Rubella (MMR, MMRV)				
Varicella (chickenpox) (VAR, MMRV)				

Vaccine	Type	Date Given (m/d/yy)	Administered By (clinic, doctor, etc)	Next Dose Date
Hepatitis A (HepA, HepA-HepB)				
Meningococcal (MCV4, MPSV4)				
Human papillomavirus (HPV4, HPV2)				
Zoster (shingles)				
Influenza (yearly) (TIV, LAIV)				
Other				

Care Schedule

Child's Name: _____

Use this form for planning and recording your child's daily care activities.

Time	Care	Initials	Notes
Morning			
Example: 8 am	*Flush feeding tube*	*MB*	
Afternoon			

Allergy Log

Child's Name:_____

Food	Reaction	Date
Ex: Peanuts	Hives	12/1/14

Medication	Reaction	Date

Other	Reaction	Date
Ex: Wool	Rash	6/18/99

Lab Work Tests and Procedures

Child's Name:_____

Date	Test	Result	Who ordered and reason	Comments
example 7/12/15	EEG	Want to repeat and do sleep test	Dr. Russ	Need to keep sleep diary

Event/Behavior Log

Child's Name: _____

Use this sheet to keep track of care activities, behaviors or events such as seizures, meltdowns, frequency of suctioning and vomiting.

Date/Time	Activity/Behavior	Comments (context, environmental issues, intensity, event or action prior to behavior)
Example Sept 20	*Major meltdown in car, kicking seat*	*Late to swim time, missed lunch, short nap*

Growth Tracking Form

Child's Name: _____

Date	Height	Weight	Height/weight percentiles	Head circumference	Checked by

Diet Tracking Form

Child's Name:_____

Date	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Meal One	*Oatmeal*						
Meal Two	*Cheese sandwich, apple, popcorn*						
Meal Three	*Chicken nuggets, broccoli*						
Other diet needs	*Ensure before bed*						
Snacks	*Carrots at 10 a.m., granola bar at 4 p.m.*						
Reactions, like/dislike, notes	*Still dislikes the strawberry ensure*						

Child's Development History Child's Name: _____

It is important to keep a record of many of your child's 'firsts'. This may help your doctor determine a diagnosis for your child and have a better idea of their developmental history.

Skill	Age	Notes
Smiled:	*3 months*	*Couldn't stop smiling*
Held up head:		
Rolled over:		
Sat up:		
Got first tooth:		
Started solid food:		
Crawled:		
Spoke first word:		
Waved "bye-bye":		
Walked:		
Spoke first sentence:		
Toilet trained:		
Played with others and shared toys:		
Other:		
Other:		
Other:		
Other:		

Call Log

Child's Name:_____

Date	Time	Caller name and phone number	Reason for call	Result of call
3/9/2013	10:42 a.m.	Jenn from Seattle Children's PT	Confirming that Benny is wearing his cast	Reassured Jenn that he is, she will check back in 1 week

Medications List

Child's Name: _____

Allergies: _____

Pharmacy: _____ **Phone:** _____ **Email:** _____

Medication	Date started	Date stopped	Dose (with or without food?)	Prescribed by

Daily Medication Tracking Sheet

Date				Child's Name:			
	Medication	Medication	Medication	Medication	Medication	Medication	Medication
Dosage							
How often							
Notes							
Time							
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
12:00 PM							
1:00 PM							
2:00 PM							
3:00 PM							
4:00 PM							
5:00 PM							
6:00 PM							
7:00 PM							
8:00 PM							
9:00 PM							
10:00 PM							
11:00 PM							
12:00 AM							
1:00 AM							
2:00 AM							
3:00 AM							
4:00 AM							
5:00 AM							

Our Family Support Resources

Support Group or Organization:	
Contact Person:	
Address:	
Website/Email:	
Phone:	
Fax:	

Support Group or Organization:	
Contact Person:	
Address:	
Website/Email:	
Phone:	
Fax:	

Support Organizations In Washington State:

- **ARC**-For families who have a child with developmental disabilities including autism, Down syndrome, Fragile X and other developmental disabilities

  Arc of King County- 877-964-0600, or 206-364-6337 www.arcofkingcounty.org

  Arc of Kitsap/Jefferson- 360-377-3473, www.arckj.org

  Arc of Grays Harbor- 866-537-7272 or 360-537-7000 www.arcgh.org

  Arc of Snohomish- 425-258-2459, www.arcsno.org

  Arc of Southwest Washington- 360-254-1562, www.arcofclarkcounty.org

  Arc of Spokane- 509-328-6326, .arc-spokane.org

  Arc of Tri Cities- 509-783-1131, www.arcoftricities.com

  Arc of Whatcom County- 360-715-0170, www.arcwhatcom.org

  Arc of Yakima County- 509-426-1292, www.arcyakimacounty.weebly.com

- **Exceptional Families Network-Piece County-** 253-830-4368, www.exceptional-families.org
- **Fathers Network - www.fathersnetwork.org** (425) 653-4286

  Serves fathers and families of children with special needs in Washington State.
- **Kindering Center- (Bellevue)**- 425-747-4004, www.kindering.org

  Emotional support and information to families of children with special needs and/or disabilities.

Our Family Support Resources

- **Northwest Special Families: King & Snohomish Counties-** 425-205-2004, www.northwestspecialfamilies.org/

  Offers support and social opportunities for children with special needs and their families.

- **Pierce County Coalition for Developmental Disabilities** - 253-564-0707 www.pc2online.org
- **Pave** http://wapave.org/- (253) 565-2266 or 1-800-5-PARENT (572-7368)

  Support, advocacy and training to empower families and individuals with disabilities.

- **Washington Parent-to-Parent-** 800-821-5927

  Matches parents with trained, experienced parents, based on similar diagnoses and family issues. Visit www.arcwa.org/index.php/getsupport/parent_to_parent_p2p_programs/coordinators to find your county's program. Visit www.p2pusa.org/ to find programs in other states.

- **National Alliance on Mental Illness –Washington (NAMI)** www.namiwa.org

  Education, support and advocacy for individuals and families affected by mental illness.

National Support Organizations:

- **Family Voices** - 800-572-7368 253-565-2266, www.familyvoices.org

  Support, advocacy, parenting and resources for children & youth with special health care needs.

- **Madison's Foundation-** www.madisonsfoundation.org

  Find other parents whose children have the same rare disease.

- **National Organization for Rare Disorders** - www.rarediseases.org/patients-and-families.

  Search by your child's diagnosis.

- **Our Kids'** - www.our-kids.org

  A list serve for families that with children with physical and/or mental disabilities and delays.

- **Partnership for Parents-** www.partnershipforparents.net

  A safety net for parents of children with serious illnesses.

- **Facebook**- Search for pages or groups related to your child's diagnosis.

Multicultural Support Organizations:

- **Open Doors for Multicultural Families** www.multiculturalfamilies.org
- **Arc of King County –Multicultural Support:** wwwarcofkingcounty.org/what-we-offer/multicultural-information-and-referral

For Siblings:

- **Sibling Support Project- www.siblingsupport.org**

School, Preschool and Developmental Center Contacts

Developmental Center/Preschool:	
Contact Person/Title:	
Phone/fax:	
Email:	
Address:	
Start date:	
End date:	
School:	
Phone/fax:	
Start date:	
End date:	
Address:	
Principal:	
Email:	
Phone:	
Teacher:	
Email:	
Phone:	
Special Ed Teacher:	
Email:	
Phone:	
School Nurse:	
Email:	
Phone:	
School Psychologist:	
Email:	
Phone:	
Aide:	
Email:	
Phone:	
Bus Contact:	
Email:	
Phone:	
School-Other:	

Equipment and Supplies

Tip: Take a picture of your child's equipment and serial numbers and save them.

Child's Name:_____

Type of Equipment:	
Description (brand name, model, size, etc.):	
Serial Number:	
Date obtained & Date expires:	
Supplier:	
Supplier Website/Email:	
Supplier Phone:	
Where is instruction manual?	

Type of Equipment:	
Description (brand name, model, size, etc.):	
Serial Number:	
Date obtained & Date expires:	
Supplier:	
Supplier Website/Email:	
Supplier Phone:	
Where is instruction manual?	

Continued on next page...

Equipment and Supplies

Type of Equipment:	
Description (brand name, model, size, etc.):	
Serial Number:	
Date obtained & Date expires:	
Supplier:	
Supplier Website/Email:	
Supplier Phone:	
Where is instruction manual?	

Type of Equipment:	
Description (brand name, model, size, etc.):	
Serial Number:	
Date obtained & Date expires:	
Supplier:	
Supplier Website/Email:	
Supplier Phone:	
Where is instruction manual?	

Type of Equipment:	
Description (brand name, model, size, etc.):	
Serial Number:	
Date obtained & Date expires:	
Supplier:	
Supplier Website/Email:	
Supplier Phone:	
Where is instruction manual?	

Tip: Call the Family Health Hotline at 1-800-322-2588 or visit www.ParentHelp123.org for help with healthcare coverage.

Insurance/Funding Sources

Insurance Company:	
Policy Number:	
Contact Person/Title:	
Address:	
Phone:	
Fax:	
Website/Email:	

Insurance Company:	
Policy Number:	
Contact Person/Title:	
Address:	
Phone:	
Fax:	
Website/Email:	

Department of Social and Human Services (DSHS)

Contact Person/Title: _____

Address: PO Box 45131 Olympia, WA 98504 _____

Phone: 1-800-737-0617 _____ **Fax:** _____

Website/Email: https://www.dshs.wa.gov/

Developmental Disabilities Administration (DDA)

Contact Person/Title: _____

Address: P.O. Box 45310 Olympia, WA 98504-5310 _____

Phone: 360-725-3413 _____ **Fax: 360-407-0955** _____

Website/Email: dddcoreception@dshs.wa.gov, https://www.dshs.wa.gov/dda

Supplemental Security Income (SSI)

Contact Person/Title: _____

Find your SSI office here: https://secure.ssa.gov/ICON/ic001.do#officeResults

Phone: 1-800-772-1213 _____ **Fax:** _____

Website/Email: http://www.socialsecurity.gov/agency/contact/