

What's the Plan?

Name:		Date of Birth:	Provider:
Parent's Name:		Today's Date:	
Questions/Concerns: What do I want to talk about today?			
What do I hope to have happen?			
Next steps? What needs to be done?			
Who will do this?			
By when? (time frame)			
How will we follow-up?			



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Center
5/07

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:		Phone:	
Address:		ER Phone:	
PHARMACY INFORMATION			
Name:		Phone:	
Address:			
OTHER			
Most Important Things to Know About Me in an Emergency:			



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Getting to Know Me

My Name:	Nickname:
Date of Birth:	Today's Date:
My Current Medicines/Doses:	
My Allergies:	
Things to Avoid: (food, activities, and procedures)	
My Equipment/Assistive Technology: (braces/orthotics, walker, wheelchair, communication device, home O ₂ , insulin pump, nebulizer, suction)	
Ways You Can be Helpful to Me:	



Getting to Know Me

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)	
My Home and Family Information:	
My Diagnosis (Diagnoses):	
My Overall Health:	
My Prior Surgeries, Procedures, Lab/Diagnostic Studies:	

