The University of Maine Center for Community Inclusion and Disability Studies,
Maine's University Center for Excellence in Developmental Disabilities Education, Research, and Service

in collaboration with

The Maine Family Advisory Council of the Children with Special Health Needs Program
Maine Department of Human Services, Bureau of Health

p r e s e n t...

the MAINE HEALTH CARE notebook

June 2004

Janet May
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Maine Department of Human Services, Bureau of Health, Children with Special Health Needs
The University of Maine Center for Community Inclusion and Disability Studies, UCEDD

The University of Maine
Center for Community Inclusion and Disability Studies
Maine's University Center for Excellence in Developmental Disabilities Education, Research and Service

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Acknowledgements

The Maine Health Care Notebook was developed to assist families who have children with special health needs keep track of important medical, financial and educational information. This publication was created with the family-centered expertise and wisdom of the Family Advisory Council of Maine's Children with Special Health Needs (CSHN) Program. Great appreciation and thanks are extended to the advisory council members:

Beverly Baker
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STATE OF MAINE
CHILDREN WITH SPECIAL HEALTH NEEDS PROGRAM
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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7TH FLOOR KEY PLAZA
AUGUSTA MAINE
04333-0011

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June 2004

Dear Caregiver(s):

As members of the Family Advisory Council (FAC) of the Children with Special Health Needs (CSHN) Program, we want to share The Maine Health Care Notebook that has been designed with you in mind as the caregiver. The Health Care Notebook was developed through the Maine Works for Youth! project, a grant that brings together the CSHN/FAC and The Center for Community Inclusion and Disability Studies at the University of Maine.

It is our hearts' desire that the Maine Health Care Notebook will be a tool that assists you in the record keeping of your child's life and medical journey. Our goal has been to simplify the Health Care Notebook so every health professional can get a quick, complete overview of your child with special health needs to better serve them.

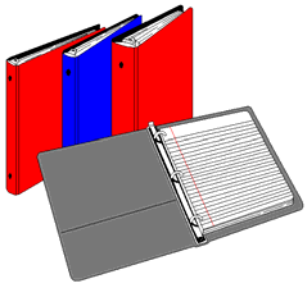
If you have questions or comments regarding the Maine Health Care Notebook, or are interested in finding out more about the Family Advisory Council for the Children with Special Health Needs Program, call 1-800-698-3624, ext. 5139 or TTY 1-800-438-5514.

From Our Special Families to Yours,

The Family Advisory Council of the
Children with Special Health Needs Program

1-800-698-3624 TTY (800) 438-5514 (207) 287-5139

Using The Maine Health Care Notebook



The Maine Health Care Notebook is an organizing tool designed to help families who have children with special health care needs keep track of important information. The Health Care Notebook is designed to be placed inside a 3-ring binder and each section is separated by color.

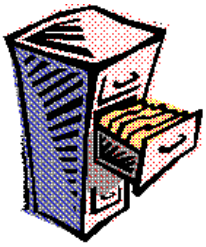
When caring for your child with special health needs, you may get information and paperwork from many sources. You may also want a place to keep track of medications, treatments, etc., that are part of the medical care your child receives. Maintaining a care notebook will help you keep the information organized in a central location. Developing your Health Care Notebook for your child will also make it easier for you to share information with others who are part of your child's care team.

The Maine Health Care Notebook can be used in many ways: to track changes in your child's medicine or treatment; to file information about your child's health history; to list contact information (telephone numbers, addresses, etc.) for health care providers and community organizations; to prepare for appointments; and to maintain information about insurance providers and other funding sources. The beauty of The Maine Health Care Notebook lies in its adaptability to each individual child and family.

Follow these steps to set up your child's notebook:

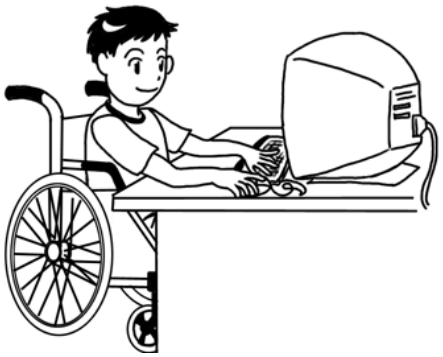
1. **Gather the information that you already have obtained.** This might include reports/notes from recent doctor visits, a summary of a hospital stay, test results, or informational pamphlets.

2. **Look through the sections within the Health Care Notebook.** Which of these pages could help you keep track of information about your child's health or care? Use the pages that you like and which make sense to you. Think about the information that you look up often. What information is needed by others caring for your child? Decide which information about your child is most important to keep in the Health Care Notebook. Make copies of forms that are useful and keep them in the notebook, too. Consider storing other information in a box or file drawer where you can find it, if needed.



3. **Put the Health Care Notebook together.** Everyone has a different way of putting information together. The most important thing is to make it easy for you to find again.

4. **Other helpful suggestions.** You may want to purchase a 3-ring binder with a clear front pocket so you can place a photograph of your child on the cover. Some families include a small calendar in their Health Care Notebook. Adding a plastic sleeve with business card holders is also useful; this is a good place to keep a phone card, too. You may wish to make extra copies of the forms you use often. You can also print extra copies from this website:



http://www.umaine.edu/cci/service/maineworks/carenotebook.htm

Your Child is a Rose

HINTS TO HELP PARENTS

- Be consistent. It's difficult to handle unwanted behavior the same way every time. But, being clear about your rules and expectations teaches your child what to expect from you.
- Be patient. This is very important. Let your child be a child – you cannot expect adult reasoning from a child's mind.
- Whenever possible, parents should try to agree and support each other in disciplining.
- Avoid accidents. Remove breakable objects, clear blocked stairways, and put household cleaners and other harmful things out of reach.
- Be good to yourself. Don't feel guilty about saying no when asked to be a PTA officer, or to going somewhere when you really don't want to.
- Allow yourself time off now and again. Hire a babysitter, or swap an afternoon of babysitting with a friend, if you can.
- When you are angry with other people or at other things, *try to let your child know that you are not angry with him/her.*
- If you feel you may lose control with your child, place your child in a safe, familiar place – a room or a crib, or with someone you trust. *Getting away from your child can help you get your emotions back under control.*
- It's normal to be angry, even to dislike your child at times. It's also normal to feel unsure of yourself as a parent, especially with a first child. Don't be afraid to discuss your fears with your doctor, a public health nurse, a friend, or another parent.

All people are a little bit different. This is true for your child, too. The following things are common to most children in their development:

- **3-12 weeks**. Your child may have episodes of screaming, especially at night. It is probably colic, a condition that commonly affects infants, about which little is known. Tension seems to make it worse, so calmness on your part could be helpful. *Do not hesitate to call your doctor if the condition continues.*
- **18-30 months**. A "no" period for your child. Children hear *no* so often that it may become one of their most used words – even when they mean yes. This stage, often referred to as the *terrible twos*, peaks at about 2 1/2 years of age with tantrums, demands, and nonstop motion. *Childproof your home to avoid accidents. You may have to remove your child from a dangerous situation.*

- **3 years**. This is a pleasant age; the child begins to say "yes." Girls identify with mother, boys with father. They are curious about the opposite sex. They are awkward, falling and stumbling often. *Whining may mean a need for more attention and nurturing.*
- **4 years**. Aggressive behavior may be seen in hitting, biting, throwing rocks, breaking toys, running away, and using bad language. *Firm, but supportive parenting is needed. Limits must be set and followed. Deal with bad language calmly.*
- **5 years**. They are generally well-behaved, content, and eager to please. This is *not* an easy age for all children, for some, separating from home and going to school is difficult. *Do whatever you can to ease your child's separation pains while encouraging independence.*
- **6 years**. The child may be emotional and stormy, wants to be independent, has to be right, may fight, cheat, and steal; accuses others of those activities, and seems to get along better with father than mother. *Be aware that the child may be having a difficult time. (Boys, in particular, may have difficulty in being away from home all day.)*
- **7 years**. The child likes to be alone, dislikes being interrupted, listens only to what (s)he wants to hear, and protects things from other children. *The child is very imaginative and likes television, but needs help to limit viewing.*
- **8 years**. The child has highs and lows, is very self-confident, may be interested in working for money, overestimates his or her ability, has a short interest span, rarely finishes projects even when eager to start, and gets frustrated over failures. *Give hints rather than detailed directions. Remain neutral: do not criticize when failure results.*
- **9 years**. There is an increasing sense of self: the child wants more freedom, may suffer from "parent deafness," and accuses parents of being unfair. The child also enjoys activity away from the family, and may worry about school projects. *Be supportive: recognize the growing need for independence. Give responsibility to make decisions about self and to participate in family decisions.*
- **10 years**. This is one of the nicest ages. The child follows family rules easily, tries to be good, likes to spend time with family, and may develop a hobby. *Encourage and enjoy!*
- **11 years**. The child may be rude and rebellious, argues, doesn't want to help around the house, and is generally difficult. The child is jealous of younger children, may do spiteful things, often quotes privileges for "other kids," is always in the refrigerator, fights and makes up, and behaves divinely away from home. *Keep demands few, but firm.*

- **12 years**. The child is enthusiastic, likes to help cook, daydreams often, is unable to plan ahead, wants independence, but may become clinging and dependent at times. Rapid physical growth and development may begin: this is a time of awkwardness and personal discomfort in dealing with a changing body. *There is a need for information from parents about sexual maturation and puberty.*

ADOLESCENCE: A TIME OF MAJOR PHYSICAL AND EMOTIONAL CHANGE

Adolescence can be a stressful time for both parents and teens. For some teens, big changes seem to happen almost overnight; other teens seem to breeze through smoothly.

In the early teens, much time is spent trying to answer "Who am I?" Older teens put lots of energy into becoming independent and separating from the family.

Many teens experiment with new ideas and lifestyles.

Adolescence may extend into the early 20's – *maturity comes when responsibility is given and accepted.*

Although it's difficult to label stages of development by age in adolescence, your teen may go through some or all of the following phases:

- **13 years**. The teen may be withdrawn and moody, locks the door to his/her room, and worries about things. Girls criticize their mothers when at home, but not elsewhere. *Privileges must be established and followed consistently.*
- **14 years**. The teen lives on the telephone, is noisy, friendly, and joyous; and likes to talk things over. In trying to find an identity, there are short outbursts of anger, pushing for more independence, but an unwillingness to compromise. The teen knows all the answers. *Praise mature behavior when it occurs: be clear about your expectations and limits. Avoid head-on collisions.*
- **15 years**. The youth may be sullen, restless, mixed-up, and self-critical. (S)he may put up a defensive front of being "tough." *The teen likes late hours out of the house. A teen of this age needs a job for self-esteem, but works better for others than for parents.*
- **16-17 years**. The teen is forming a clearer self-image and is usually friendly and good-tempered. (S)he is interested in people, and needs to share feelings and experiences with friends. Young people of this age are very interested in the opposite sex and fall in and out of love. Girls physically mature around age 16, boys at about age 17. The teen wants to be treated as an adult, and defines independence as having no responsibilities to the family. *Parents should recognize and respect privacy and independence needs when possible.*

- **17 years +**. The youth is concerned about the future and may feel insecure at times. The teen is idealistic, questions and explores beliefs, and criticizes authority figures. Separation from home is usually difficult for both parents and teens; there are mixed feeling of joy and pain. *Try not to preach. Allow the youth space to make mistakes.*

BLOSSOMS AND THORNS

In the blossoming of a child, it may seem at times that there are more thorns than blossoms. Learn about the various stages of behavior that children go through. Call your family doctor, public health nurse, or contact a local parent support group for more information.

Family Information

Emergency Information Sheet

Name _____
Address _____
Contact Numbers _____

DOB_____
SS#_____
Language spoken in home _____

PRIMARY DIAGNOSIS_____
Date_____ Height_____ Weight_____ Blood Type_____
Date_____ Height_____ Weight_____
Date_____ Height_____ Weight_____
Date_____ Height_____ Weight_____

MEDICAL

PHYSICIAN	HOSPITAL
Name_____	Name_____
Address_____	Address_____
Phone_____	Phone_____
Fax_____	Fax_____
MEDICATIONS	**ALLERGIES**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

INSURANCE

Name_____	Name_____
Address_____	Address_____
Phone_____	Phone_____
Group #_____	Group #_____
Policy #_____	Policy #_____
Certificate #_____	Certificate #_____

HEALTH SURROGATE_____
BC/BS CASE MANAGER_____
HEALTH VENDOR_____
HOME NURSING AGENCY_____

Developed by Patti Hackett, Co-Director, Healthy & Ready to Work National Center.

Briefly describe what your child is like usually (how active and aware of surroundings, how responsive to others, and any physical differences that are typical for your child such as noisy breathing, etc.).

Date: _____

Updated on: _____

Updated on: _____

Updated on: _____

Name _____ DOB _____

IF YOUR CHILD HAS HAD A MEDICAL EMERGENCY IN THE PAST, what was the emergency and what worked best to treat it?

Date: _____

Date: _____

Date: _____

Date: _____

Name _____ DOB _____

Household Emergency Information

My Address: _____

Directions to my house: _____

_____

_____

_____

_____

_____

~~~~~~

Fire Department Number: _____

Police Department Number: _____

Ambulance: _____

Poison Control Hotline: _____

Crisis Hotline: _____

~~~~~~

Fire Escape Plan: _____

_____

_____

_____

_____

_____

_____

_____

~~~~~~

Monthly Check of Smoke Alarms:

Jan _____	Feb _____	March _____	April _____
May _____	June _____	July _____	Aug _____
Sep _____	Oct _____	Nov _____	Dec _____

~~~~~~

Monthly Check of Fire Extinguishers:

Jan _____	Feb _____	March _____	April _____
May _____	June _____	July _____	Aug _____
Sep _____	Oct _____	Nov _____	Dec _____

Name _____ DOB _____

Emergency Contact Person(s)

Name _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____ Relationship _____

Name _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____ Relationship _____

Name _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____ Relationship _____

Name _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____ Relationship _____

Name _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____ Relationship _____

Name _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____ Relationship _____

Birth Information

Mother's Maiden Name _____
Last First Middle

Father's Name _____
Last First Middle

Foster Parent/Guardian _____

Names of brothers and sisters _____

_____

_____

_____

Hospital (birth) _____

Birth weight _____ lbs. _____ oz. Length _____ inches

APGAR Score _____ Gestation Age _____ Weeks _____

Diagnosis _____

_____

_____

Doctor _____

Complications at birth _____

_____

_____

Prenatal medical care of mother:

_____ Regular _____ Erratic _____ Absent

When was prenatal care begun _____

Was oxygen used for baby after delivery? _____

Blood type of child _____

Name _____ DOB _____

Adapted from *Medical Passport* (unpaged) by the Indiana Sate Department of Health Children's Special Health Care Services, 1-800-475-1355, printed (n.d.), Project MCJ-18IS23-02.

My Child's Preferences

Child's Preferred Language/Methods of Communication: _____

_____

Child's Ethnicity/Race: _____

Family's Preferred Language: _____

Family's religious beliefs and/or customs that may affect medical treatment:

_____

_____

_____

Ways of Communicating: _____

(Sign, use of equipment, TTY, communication board, etc.)

Do specific words/gestures have special meanings? _____

_____

_____

_____

_____

Child's Likes and Dislikes

Likes: _____

Dislikes: _____

Child's Strengths

_____

_____

_____

_____

Favorites

Food(s): _____

Songs: _____

Music: _____

Toys: _____

Friend(s): _____

Other People/Things: _____

Name _____ DOB _____

Adapted from *Medical Passport* (unpaged) by the Indiana Sate Department of Health Children's Special Health Care Services, 1-800-475-1355, printed (n.d.), Project MCJ-18IS23-02.

BRIEF MEDICAL HISTORY

Name: _____

DOB: _____

Blood Type: _____

Insurance Name:	Policy #:	Address:
Ins. Phone #		P.O.C.
2nd Insurance Name:	Policy #:	Address:
Ins. Phone:		P.O.C.

Conditions	Date	Condition/Procedure	Place	Doctor

Name _____ DOB _____

Child's Name _____ DOB _____

Allergies:			
Current Medications:			
Special Conditions:			
X-ray/Scans:			

Name _____ DOB _____

Biological Family History

Mother's Health

- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Smoker
- ❑ Kidney Problems
- ❑ Asthma
- ❑ Epilepsy, Seizures
- ❑ Birth Defects*
- ❑ Deafness*
- ❑ Death **UNDER** 50 years of age*
- ❑ Other*
- ❑ DES Use
- ❑ Menstrual Problems*
- ❑ Heart Attack **UNDER** 60 years of age
- ❑ Stroke
- ❑ Stomach/Intestinal
- ❑ Mental Retardation
- ❑ Blood Disease
  - ❑ (a) Anemia ❑ (b) Sickle Cell
- ❑ Allergies
- ❑ Bone/Joint Problems
- ❑ High Cholesterol
- ❑ Cancer
- ❑ Urinary Problems
- ❑ Muscle/Nerve Diseases

* Please Explain:

_____

_____

_____

_____

Father's Health

- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Smoker
- ❑ Kidney Problems
- ❑ Asthma
- ❑ Epilepsy, Seizures
- ❑ Birth Defects*
- ❑ Deafness*
- ❑ Death **UNDER** 50 years of age*
- ❑ Other*
- ❑ Urinary Problems
- ❑ Heart Attack **UNDER** 60 years of age
- ❑ Stroke
- ❑ Stomach/Intestinal
- ❑ Mental Retardation
- ❑ Blood Disease
  - ❑ (a) Anemia ❑ (b) Sickle Cell
- ❑ Allergies
- ❑ Bone/Joint Problems
- ❑ High Cholesterol
- ❑ Cancer
- ❑ Muscle/Nerve Diseases

* Please Explain:

_____

_____

_____

_____

Name _____ DOB _____

Adapted from *Medical Passport* (unpaged) by the Indiana Sate Department of Health Children's Special Health Care Services, 1-800-475-1355, printed (n.d.), Project MCJ-18IS23-02.

Child and Family Information

Child's Name _____ Nickname _____

Date of Birth _____ Social Security Number _____

Child's Address _____

_____ Child's Phone ( ) _____

~~~~~~

Emergency Contact Person _____

Daytime Phone ( ) _____ Evening Phone ( ) _____

Relationship to child _____

Address _____

~~~~~~

Mother's Name _____

Address _____

Daytime Phone ( ) _____ Evening Phone ( ) _____

Email address _____

~~~~~~

Father's Name _____

Address _____

Daytime Phone ( ) _____ Evening Phone ( ) _____

Email address _____

~~~~~~

Siblings:

Name	_____	DOB	_____	Name	_____	DOB	_____
Name	_____	DOB	_____	Name	_____	DOB	_____
Name	_____	DOB	_____	Name	_____	DOB	_____
Name	_____	DOB	_____	Name	_____	DOB	_____
Name	_____	DOB	_____	Name	_____	DOB	_____
Name	_____	DOB	_____	Name	_____	DOB	_____

Name _____ DOB _____

Adapted from *Medical Home Project* by the American Academy of Pediatrics, Arizona Chapter, 2303 E. Thomas Road, Phoenix, AZ 85016, printed (n.d.).

Child and Family Information

Guardian/Guardian ad litem/Foster Parent (please identify which one)

____

Guardian's Address ______________________________

Daytime Phone ( ) ____________ Evening Phone ( ) ____________

Email address ______________________________

~~~~~~

Child Care Provider ______________________________

Relationship to Child ______________________________

Address ______________________________

Daytime Phone ( ) ____________ Evening Phone ( ) ____________

Email address ______________________________

~~~~~~

School ____________________ Child's Grade Level ____________

School Address ______________________________

School Phone ( ) ____________ Principal ____________

Teachers ____________ ____________

____________ ____________

____________ ____________

Guidance Counselor ______________________________

Counselor at School ____________________ Phone ( ) ____________

~~~~~~

Other Services

Agency ______________________________

Case Manager/Title ______________________________

Address ______________________________

Daytime Phone ( ) ____________ Evening Phone ( ) ____________

Email address ______________________________

Name ____________________ DOB ____________
~~~~~~

Funding/ Financial Information

Insurance Information

Primary Insurance _____ Plan # _____
Group # _____ Child's ID # _____
Subscriber's Name _____
Subscriber's Social Security # _____
Mailing Address _____
Phone Number _____
Comments:

~~~~~~

Dental Insurance _____ Plan # _____
Group # _____ Child's ID # _____
Subscriber's Name _____
Subscriber's Social Security # _____
Mailing Address _____
Phone Number _____
Comments:

~~~~~~

Drug Card or Prescription Insurance _____ Plan # _____
Group # _____ Child's ID # _____
Subscriber's Name _____
Subscriber's Social Security # _____
Mailing Address _____
Phone Number _____
Comments:

~~~~~~

MaineCare (i.e. Medicaid, Katie Beckett waiver)# _____
MaineCare ID # _____
Subscriber's Name _____
Subscriber's Social Security # _____
Mailing Address _____
Case Worker's Name and Phone Number _____
Comments:

Name _____ DOB _____

Adapted from *Health Notebook* by Kennebec Pediatrics, 263 Water Street, Augusta, Maine 04330, 207-623-2977, printed (n.d.).
~~~~~~

Referral Information Sheet

Children with Special Health Needs Program _____
Mailing _____
Case Worker's _____
Case Worker's Phone _____
Comments:

~~~~~~

Referred To _____
Date Referral Called In _____
Reason _____
_____
Date Referral Received _____
Referral # _____

~~~~~~

Phone #'s for Referrals _____

Name _____ DOB _____

Adapted from *Health Notebook* by Kennebec Pediatrics, 263 Water Street, Augusta, Maine 04330, 207-623-2977, printed (n.d.).

Medical Bill Tracking Form

Date	Patient	Provider	Cost	Insurance Paid	Family Owes	Date Paid

Name _____ DOB _____

Adapted from *Care Notebook* by Children's Hospital and Regional Medical Center, 4800 Sand Point Way NE, PO Box 5371, Seattle, Washington, Washington State Department of Health & Office of Children with Special Health Care Needs, printed (March, 1998).

Out-of-Pocket Expenses

Use this sheet to track expenses not covered by insurance.
This sheet may be helpful for income tax purposes.

Date	Activity (travel, mileage, lodging, supplies, etc.)	Cost

Name _____ DOB _____

Medical Provider Information

Health Care Providers

Primary Medical Provider _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Preferred Hospital _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Specialty Hospital _____
Address _____
City _____ State _____ Zip _____
Phone ( )
Email _____

Specialist Name _____ Type _____
Clinic/Hospital _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Specialist Name _____ Type _____
Clinic/Hospital _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Name _____ DOB _____

Adapted from *Medical Passport* (unpaged) by the Indiana Sate Department of Health Children's Special Health Care Services, 1-800-475-1355, printed (n.d.), Project MCJ-18IS23-02.

Specialist Name _____ Type _____
Clinic/Hospital _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Specialist Name _____ Type _____
Clinic/Hospital _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Specialist Name _____ Type _____
Clinic/Hospital _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Dentist Name _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Orthodontist Name _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Adapted from *Medical Passport* (unpaged) by the Indiana Sate Department of Health Children's Special Health Care Services, 1-800-475-1355, printed (n.d.), Project MCJ-18IS23-02.

Public Health Nurse _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Nutritionist _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Social Worker _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Healthy Families Contact _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Home Health Agency _____

Start Date _____ End Date _____

Contact Person _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Adapted from *Medical Passport* (unpaged) by the Indiana Sate Department of Health Children's Special Health Care Services, 1-800-475-1355, printed (n.d.), Project MCJ-18IS23-02.

Home Health Agency _____

Start Date _____ End Date _____

Contact Person _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Home Health Agency _____

Start Date _____ End Date _____

Contact Person _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Pharmacy _____

Contact Person _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Pharmacy _____

Contact Person _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Name _____ DOB _____

Adapted from *Medical Passport* (unpaged) by the Indiana Sate Department of Health Children's Special Health Care Services, 1-800-475-1355, printed (n.d.), Project MCJ-18IS23-02.

Occupational Therapist (OT) _____

Start Date _____ End Date _____

Agency _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Physical Therapist (PT) _____

Start Date _____ End Date _____

Agency _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Speech-Language Pathologist _____

Start Date _____ End Date _____

Agency _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Other Therapist _____

Start Date _____ End Date _____

Agency _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Adapted from *Medical Passport* (unpaged) by the Indiana Sate Department of Health Children's Special Health Care Services, 1-800-475-1355, printed (n.d.), Project MCJ-18IS23-02.

Other Therapist _____

Start Date _____ End Date _____

Agency _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Respite Care Provider _____

Start Date _____ End Date _____

Agency _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Respite Care Provider _____

Start Date _____ End Date _____

Agency _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Adapted from *Medical Passport* (unpaged) by the Indiana Sate Department of Health Children's Special Health Care Services, 1-800-475-1355, printed (n.d.), Project MCJ-18IS23-02.

Dental Record

Child's Name _____

Dentist's Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

- ❑ Dentist has been informed of child's medical condition and medical specialists' recommendations.

All children should have routine dental care. Such care may be even more important when your child has a special health care need. He or she may need to be treated by a dentist with special skills. Consult with your family dentist or your child's medical specialist to determine if he or she requires specialized dental services.

Before your child is examined, the dentist should have information regarding your child's medical condition or current care. Any precautions recommended by your child's medical specialist should be discussed with the dentist. It is also essential that you provide the dentist with a list of current medications received by your child.

You may wish to use the space below to keep track of your child's dental appointments.

Date	Time	Appointment Information

Name _____ DOB _____

Adapted from *Coordinated Care Record* by The University of Illinois at Chicago, Division of Specialized Care for Children printed (July, 1989).

Medical Information

Child's Medical History

Chronic Health Problems:		C = CURRENT P = PAST		
C	**P**	**Problems**	**Procedure done & Location**	**Results**
❑	❑	Ear Infection		
❑	❑	Feeding Problems		
❑	❑	Eczema		
❑	❑	Bone/Joint Problems		
❑	❑	Asthma		
❑	❑	Heart		
❑	❑	Seizures		
❑	❑	Diabetes		
❑	❑	Developmental Delay		
❑	❑	Upper Respiratory Infections		
❑	❑	Overweight		
❑	❑	Underweight		
❑	❑	Dental Caries		
❑	❑	Anemia		
❑	❑	Sickle Cell		
❑	❑	Control/Problem w/bowels		
❑	❑	Excessive vomiting		
❑	❑	Psychological problem (type)		
❑	❑	Neurological problem (type)		
❑	❑	Allergies		
❑	❑	Failure to thrive		
❑	❑	Other chronic problems		

Name _____ DOB _____

Adapted from *Medical Passport* (unpaged) by the Indiana Sate Department of Health Children's Special Health Care Services, 1-800-475-1355, printed (n.d.), Project MCJ-18IS23-02.

TRAUMA:
(e.g., fractures, head injuries, burns)

~~~~~~

CHILDHOOD ILLNESSES:

❑ Chickenpox	Date _____	❑ German Measles (Rubella)	Date _____
❑ Infectious Mononucleosis	Date _____	❑ Measles (Rubeola)	Date _____
❑ Meningitis	Date _____	❑ Mumps	Date _____
❑ Roseola	Date _____	❑ Scarlet Fever	Date _____
❑ Rheumatic Fever	Date _____		

❑ Other _____

~~~~~~

SENSORY PROBLEMS:

Date	Problem	Procedure done & location	Results
	Newborn Hearing Screening		
	Vision		
	Vision		
	Vision		
	Vision		
	Hearing		
	Hearing		
	Hearing		
	Hearing		
	Other		
	Other		
	Other		
	Other		

Name _____ DOB _____

Adapted from *Medical Passport* (unpaged) by the Indiana Sate Department of Health Children's Special Health Care Services, 1-800-475-1355, printed (n.d.), Project MCJ-18IS23-02.

Developmental Milestones

This is a list of developmental milestones. **Please give approximate date when the child did each of the following**. If you can't remember the specific age, but know the child has mastered this skill, simply check ✓.

FEEDING SKILLS

_____ Formula/Breast fed only	____ Needs to be fed	_____ Eats solid food
_____ Uses cup independently	____ Needs assistance with feeding	_____ Feeds self with spoon
_____ Solid food started	____ Holds own bottle	_____ Feeds self with fork
_____ Eats soft foods only	____ Finger feeds	_____ Other: _____
_____ Sucks/Chews on crackers		

Comments: _____

UPPER BODY SKILLS

_____ Head needs support	____ Rolls over	_____ Sits independently
_____ Holds head steady	____ Sits with support	_____ Other: _____

Comments: _____

LOWER BODY SKILLS, MOBILITY

_____ Scoots	____ Cruises holding on to things	_____ Runs, skips and/or jumps
_____ Crawls on hands & knees	____ Walks with assistance	_____ Other: _____
_____ Pulls to standing	____ Walks independently	

Comments: _____

COMMUNICATION SKILLS

_____ Eye gazes (familiar face, name voice)	____ Smiles	_____ Uses single word/phrases
_____ Grunts	____ Points	_____ Talks in sentences
_____ Babbles, no word yet	____ Uses eye gestures	_____ Speaks clearly

SELF HELP OR ADAPTIVE SKILLS

_____ Cooperates in dressing	____ Dresses independently	_____ Fully toilet-trained
_____ Removes socks, shoes	____ Wears diapers	_____ Other: _____
_____ Needs to be dressed	____ Toilet training in process	_____ Other: _____

Name _____ DOB _____

Adapted from *Medical Passport* (unpaged) by the Indiana Sate Department of Health Children's Special Health Care Services, 1-800-475-1355, printed (n.d.), Project MCJ-18IS23-02.

Medications Summary Sheet

Long Term Medications

Ask your Health Care Provider or Pharmacist for information about all medications.

Name of Medication	Date Started	Date Ended	Dosage Route	Time of Day Given	Reason for Taking	Prescribed by:	Side Effects Observed

Name _____ DOB _____

Medications Summary Sheet, continued

Short Term Medications

Ask your Health Care Provider or Pharmacist for information about all medications.

Name of Medication	Date Started	Date Ended	Dosage Route	Time of Day Given	Reason for Taking	Prescribed by:	Side Effects Observed

Name _____ DOB _____

Durable Medical Equipment/Supplies

Name of Equipment: _____

Description (brand name, size, etc.): _____

_____

_____

Supplier: _____ Date obtained: _____

Contact Person: _____ Phone: ( )

Name of Equipment: _____

Description (brand name, size, etc.): _____

_____

_____

Supplier: _____ Date obtained: _____

Contact Person: _____ Phone: ( )

Name of Equipment: _____

Description (brand name, size, etc.): _____

_____

_____

Supplier: _____ Date obtained: _____

Contact Person: _____ Phone: ( )

Name of Equipment: _____

Description (brand name, size, etc.): _____

_____

_____

Supplier: _____ Date obtained: _____

Contact Person: _____ Phone: ( )

Name _____ DOB _____

Adapted from *Care Notebook* by Children's Hospital and Regional Medical Center, 4800 Sand Point Way NE, PO Box 5371, Seattle, Washington, Washington State Department of Health & Office of Children with Special Health Care Needs, printed (March, 1998).

Medical Lab Work/Tests/Procedures

Date	Type of Test	Result	Hospital/Clinic	Comments

Name _____ DOB _____

Adapted from *Care Notebook* by Children's Hospital and Regional Medical Center, 4800 Sand Point Way NE, PO Box 5371, Seattle, Washington, Washington State Department of Health & Office of Children with Special Health Care Needs, printed (March, 1998).

Growth Tracking Form

Date	Height	Weight	Checked By

Name _____ DOB _____

Adapted from *Care Notebook* by Children's Hospital and Regional Medical Center, 4800 Sand Point Way NE, PO Box 5371, Seattle, Washington, Washington State Department of Health & Office of Children with Special Health Care Needs, printed (March, 1998).

Child's Illness/Infection/Injury Report

Child's Name: _____

Illness/Infection or Injury*	Date	How Long it Lasted	Drugs Taken/Treatment	Physician	Hospital/ Clinic

* Write down serious injuries only, those that require a doctor's attention.

Name _____ DOB _____

Immunizations

	DTP	Polio	Measles Mumps Rubella	Hib Disease	Adult Tetanus	Hepatitis B	Varicella (chickenpox)	Physician Signature
Date								
Date								
Date								
Date								
Date								
Date								
Date								
Date								
Date								
Date								
Date								
Date								
Date								
Date								
Date								
Date								

	Date	Date	Date	Date	Date	Date	Date	Physician Signature
Flu Vaccine								
Pneumococcal Vaccine								
Meninococcal Vaccine								

Name _____ DOB _____

Adapted from *Health Notebook* by Kennebec Pediatrics, 263 Water Street, Augusta, Maine 04330, 207-623-2977, printed (n.d.).

Seizure Activity

Watch and record any changes in seizure activity.

Date/Time	Duration	Description (Extremities, Intensity)

Name _____ DOB _____

Other Service Providers

Family Support Resources

Parent-to-Parent _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Parent Group _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Religious Organization _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Service Organization _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Counseling Services _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Other _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Name _____ DOB _____

Transportation Agency _____
Contact Person _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Transportation Agency _____
Contact Person _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Respite Care Provider _____
Start Date _____ End Date _____
Agency _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Respite Care Provider _____
Start Date _____ End Date _____
Agency _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Respite Care Provider _____
Start Date _____ End Date _____
Agency _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

School/Preschool _____

Principal _____

School Contact _____

Start Date _____ End Date _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

School Nurse _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Teacher _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Special Education Teacher _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Other _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Care Summaries

Home Care Plan

Name: _____ DOB: _____ Date: _____

Existing Conditions/Diagnoses:_____

Visit's Purpose: Physical___ Sick Visit___ Sports/Camp___ Immunization___ Other_____

*** * * * * * PARENTS SECTION * * * * * ***

Problems to talk about today:

- _____
- _____
- _____

Medications and dosages:

- _____
- _____
- _____

*** * * * * * HEALTH CARE PROVIDERS SECTION * * * * * ***

Problem review:

- _____
- _____
- _____

*** * * PHYSICAL EXAM * * ***

Condition	Gen.	E.N.T.	Neck	Lungs	Heart	Abdom.	Mus./Skel.	Neuro	Skin	Other
Normal										
Abnormal										

Abnormality explanation: _____

_____

Height: _____ Weight: _____ BP: _____ HR: _____ Temperature: _____

Assessments/Diagnoses:

- _____
- _____

Recommendations/Referrals:

- _____
- _____

Med. Changes: _____

Testing Dates: _____

Location: _____

Next CP: _____ Vaccines due: _____ Flu Shot: Yes___ No___ Due? ___

Doctor's Signature: _____

Name _____ DOB _____

Developed by Winthrop Family Pediatrics Center, 15 Old Western Ave., Winthrop, ME 04364, (207) 377-2114, printed (n.d.).

Care Summary Sheet - - Primary Care Provider

Date_____

Provider Name_____

Agency_____

Immunizations Required?_____

Needs Physical Exam?_____

Reason for Visit_____

_____

_____

Diagnosis_____

Treatment_____

_____

Follow Up – Appointment_____

Notes:

~~~~~~

Care Summary Sheet - - Primary Care Provider

Date_____

Provider Name_____

Agency_____

Immunizations Required?_____

Needs Physical Exam?_____

Reason for Visit_____

_____

_____

Diagnosis_____

Treatment_____

_____

Follow Up – Appointment_____

Notes:

Name _____ DOB _____

Adapted from *Health Notebook* by Kennebec Pediatrics, 263 Water Street, Augusta, Maine 04330, 207-623-2977, printed (n.d.).
~~~~~~

Care Summary Sheet - - Eye Care

Date_____

Provider Name_____

Agency_____

Visual Acuity_____

_____

_____

Reason for Visit_____

_____

_____

Diagnosis_____

Treatment_____

_____

Follow Up – Appointment_____

Notes:

~~~~~~

Care Summary Sheet - - Eye Care

Date_____

Provider Name_____

Agency_____

Visual Acuity_____

_____

_____

Reason for Visit_____

_____

_____

Diagnosis_____

Treatment_____

_____

Follow Up – Appointment_____

Notes:

Name _____ DOB _____

Adapted from *Health Notebook* by Kennebec Pediatrics, 263 Water Street, Augusta, Maine 04330, 207-623-2977, printed (n.d.).
~~~~~~

Care Summary Sheet - - Dental Care

Date_____

Provider Name_____

Agency_____

Fluoride: Yes No

Comments:_____

_____

Reason for Visit_____

_____

_____

Diagnosis_____

Treatment_____

_____

Follow Up – Appointment_____

Notes:

~~~~~~

Care Summary Sheet - - Dental Care

Date_____

Provider Name_____

Agency_____

Fluoride: Yes No

Comments:_____

_____

Reason for Visit_____

_____

_____

Diagnosis_____

Treatment_____

_____

Follow Up – Appointment_____

Notes:

Name _____ DOB _____

Adapted from *Health Notebook* by Kennebec Pediatrics, 263 Water Street, Augusta, Maine 04330, 207-623-2977, printed (n.d.).
~~~~~~

Care Summary Sheet - - Specialist Care

Date_____

Provider Name_____

Agency_____

Specialty:

_____

Reason for Visit_____

_____

_____

Diagnosis_____

Treatment_____

_____

Follow Up – Appointment_____

Notes:

~~~~~~

Care Summary Sheet - - Specialist Care

Date_____

Provider Name_____

Agency_____

Specialty:

_____

Reason for Visit_____

_____

_____

Diagnosis_____

Treatment_____

_____

Follow Up – Appointment_____

Notes:

Name _____ DOB _____

Adapted from *Health Notebook* by Kennebec Pediatrics, 263 Water Street, Augusta, Maine 04330, 207-623-2977, printed (n.d.).
~~~~~~

Care Summary Sheet - - Child Psychiatry

Date_____

Provider Name_____Agency_____

Reason for Visit_____

_____

Diagnosis Axis I_____

Axis II_____

Axis III_____

Axis IV_____

Treatment Goal_____

Treatment Method_____

_____

Follow Up-Appointment_____

Notes:

~~~~~~

Care Summary Sheet - - Child Psychiatry

Date_____

Provider Name_____Agency_____

Reason for Visit_____

_____

Diagnosis Axis I_____

Axis II_____

Axis III_____

Axis IV_____

Treatment Goal_____

Treatment Method_____

_____

Follow Up-Appointment_____

Notes:

Name _____ DOB _____

Adapted from *Health Notebook* by Kennebec Pediatrics, 263 Water Street, Augusta, Maine 04330, 207-623-2977, printed (n.d.).
~~~~~~

Care Summary Sheet - - Counselor/Therapist

Date_____

Provider Name_____Agency_____

Reason for Visit_____

_____

Diagnosis Axis I_____

Axis II_____

Axis III_____

Axis IV_____

Treatment Goal_____

Treatment Method_____

_____

Follow Up-Appointment_____

Notes:

~~~~~~

Care Summary Sheet - - Counselor/Therapist

Date_____

Provider Name_____Agency_____

Reason for Visit_____

_____

Diagnosis Axis I_____

Axis II_____

Axis III_____

Axis IV_____

Treatment Goal_____

Treatment Method_____

_____

Follow Up-Appointment_____

Notes:

Name _____ DOB _____

Adapted from *Health Notebook* by Kennebec Pediatrics, 263 Water Street, Augusta, Maine 04330, 207-623-2977, printed (n.d.).
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Calendar and Appointments

"Make-A-Calendar"

Month _____ Year _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Name _____ DOB _____

Telephone Call and Correspondence Log

Date	Individual	Organization	Why?

Name _____ DOB _____

Personal Contacts

Name/Address	Phone	
	Office	
	Fax	
	Cell	
	Email	

Name/Address	Phone	
	Office	
	Fax	
	Cell	
	Email	

Name/Address	Phone	
	Office	
	Fax	
	Cell	
	Email	

Name/Address	Phone	
	Office	
	Fax	
	Cell	
	Email	

Name/Address	Phone	
	Office	
	Fax	
	Cell	
	Email	

Name _____ DOB _____

ETC.

Education Record

Child's Name _____

Once your child is in a birth-to-three program, a special education program, or in a regular classroom, keeping track of his or her progress is important. If there is ever a problem with how your child is doing in school, a record of what has happened in the past will be valuable to you and the teachers providing your child's education!

Date	Program/ School	Address	Telephone	Type of Program/ Class	Progress Made

Name _____ DOB _____