CARE PLAN

BASIC INFORMATION		
Child's Name:	Birthdate:	Nickname:
Home Address:		
Home Phone:	Emergency Contact Names & Relationship:	
Primary Language		
Phone Number(s):		

PHYSICIANS	
Primary Care Physician/Pediatrician:	Emergency (Exchange) Phone:
	Fax:
Current Specialty Physician:	Emergency Phone:
Specialty:	Fax:
Current Specialty Physician:	Emergency Phone:
Specialty:	Fax:
Closest Preferred Emergency Room:	Pharmacy:

DIAGNOSES/PAST PROCEDURES/PHYSICAL EXAM	
1. _____ _____ 2. _____ _____ 3. _____ _____ 4. _____ _____ Synopsis: _____ _____ _____	Baseline physical findings:_____ _____ _____ _____ Baseline vital signs: _____ _____ _____ _____ Baseline neurological status: _____ _____ _____ _____

Contact Misty A. Watson
mwatson@dmfirm.com
314-889-7155

CARE PLAN

DIAGNOSES/PAST PROCEDURES/PHYSICAL EXAM, continued

Medications (dosage, time of day):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Significant baseline ancillary findings (lab, x-ray, EKG):

_____
_____
_____

Prostheses/Appliances/Advanced Technology Devices:

_____
_____
_____

MANAGEMENT DATA

Allergies: Medication/Foods to be avoided

1. _____
2. _____
3. _____

Procedures to be avoided

1. _____
2. _____

And why:

_____
_____
_____

And why:

_____
_____
_____

IMMUNIZATIONS (mm/yy)

Dates					
DPT					
OPV					
MMR					
HIB					
Hep B					

Dates					
Varicella					
TB status					
Other					
Other					
Other					

COMMON PRESENTING PROBLEMS/FINDINGS WITH SPECIFIC SUGGESTED MANAGEMENTS

Problem Suggested Diagnostic Studies Treatment Considerations

_____
_____
_____

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NEEDED ACCOMMODATION(S)
Describe any needed accommodation (s) the child needs in daily activities and why: Diet or Feeding: _____ _____ Classroom Activities: _____ _____ Naptime/Sleeping: _____ _____ Toileting: _____ _____ Outdoor or Field Trips: _____ _____ Transportation: _____ _____ For Behavior Changes: _____ _____ Phobias or Fears and techniques for managing: _____ _____

CLOSE FRIENDS OF CHILD AND CONTACT INFORMATION	
1. _____	Phone Number: _____ Address: _____ _____
2. _____	Phone Number: _____ Address: _____ _____
3. _____	Phone Number: _____ Address: _____ _____
4. _____	Phone Number: _____ Address: _____ _____
5. _____	Phone Number: _____ Address: _____ _____

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SCHOOL OR WORK INFORMATION, SUPPORT

SCHOOL
Name and address of School: _____
Name of Special Education Teachers:_____
Date of Last IEP:_____
Any educational concerns:_____
Type of transportation to and from school:_____

WORKPLACE
Name and address of workplace: _____
Contact person and phone number at workplace:
_____
Type of transportation to and from workplace:_____
Contact person and phone number for transportation to and from workplace:_____
_____

RESPITE CARE AND LONG TERM PLAN
Name and contact information for persons who have previously cared for child:_____
_____
Name and contact information of organizations providing temporary care:_____
_____
List any long term care arrangements that have been made and how such arrangements shall be financially compensated (i.e., private pay, Medicaid, accepts social security, etc.):
_____
_____
_____
_____
_____

NAME AND CONTACT INFORMATION OF PARENTS WITH CHILDREN WITH SIMILAR NEEDS	
1. _____	Phone Number: _____ Address: _____ _____
2. _____	Phone Number: _____ Address: _____ _____
3. _____	Phone Number: _____ Address: _____ _____

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