Health Summary
for Your Child with Special Health Care Needs

Want to get the best health care for your child?

1) **Write down** your child's health care information as soon as you get it.
2) **Share** this information with your health care providers.

This form will help you keep track of the health information you'll need.

Tips for using this form:

- You don't have to fill out every line - just what applies to your child.
- Be sure to ask your health care provider if you have *any* questions or concerns.
- Protect your child's Social Security number and other personal information. Store completed copies of this form and other health records in a safe place at home.
- Remember to bring this form with you to appointments.

For a blank form, call the NYS Department of Health at 1-518-473-9883, or go to www.health.ny.gov/community/special_needs

Other health summary forms:

Health Care Notebook*:* *Parent-to-Parent of New York State* is an organization that serves families of children with special health care needs. It has developed a Health Care Notebook that can be placed in a 3-ring binder. You can download a complete Health Care Notebook, or just the pages you need at the Parent-to-Parent website, www.parenttoparentnys.org. You can also call 1-800-305-8817 to get the number of your local Parent-to-Parent office.

Emergency Information Form for Children with Special Needs: Work with your health care provider to complete this form in case your child has an emergency. You or your doctor can find this form at: www.aap.org/advocacy/blankform.pdf.

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Health Summary for Your Child with Special Health Care Needs

Name of Child:_____ DOB:_____

Child's Nickname:_____ Soc. Security #:_____ (Optional)

Parent/Guardian:_____ Phone (home):_____

Parent/Guardian E-mail:_____ Phone (cell/work):_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Insurance Company:_____ ID #:_____ Group #:_____

Child's Main Diagnosis:_____

Other Diagnoses or Major Injuries: _____

_____

Special Care Needs of Your Child

Allergies: Include medicine, food, environment, contact, or other. Also describe what happens.

1._____ What happens:_____

2._____ What happens:_____

3._____ What happens:_____

- Main language, or way to communicate_____
- Describe any challenges with movement, hearing, eyesight, or thinking:

  _____

  _____
- Special safety instructions/crisis plan:_____

  _____
- Special conditions, treatment challenges, unusual findings, or equipment used (type & size):

  _____

  _____

Usual Doctor:_____ Phone:_____ Fax:_____

Address: _____ Email:_____

Hospital you prefer:_____ Phone:_____

Pharmacy Name:_____ Phone:_____

Major Surgeries and Hospitalizations

Where:_____Why:_____Date:_____

Where:_____Why:_____Date:_____

Where:_____Why:_____Date:_____

Where:_____Why:_____Date:_____

Medicines (Drugs) your child is taking:

Name of medicine	For what reason	Amount (Dose) and how often	Doctor who ordered

Medicines (Drugs) tried in the past that didn't work, and what happened

_____

_____

_____

Additional Health Care Providers

Name:_____Reason:_____Phone:_____

Name:_____Reason:_____Phone:_____

Name:_____Reason:_____Phone:_____

Name:_____Reason:_____Phone:_____

Usual Dentist: _____Phone:_____Fax:_____

Address: _____Email:_____

Other Care Providers

School Contact:_____Phone:_____ E-mail:_____

Therapist:_____Phone:_____ E-mail:_____

Other:_____Phone:_____ E-mail:_____

Immunizations (Shots)	**Date**	**Date**	**Date**	**Date**	**Date**
Diphtheria Pertussis (DPT/DTaP) Tetanus					
Polio					
Mumps Measles (MMR) Rubella					
Hib (Haemophilus influenza type b)					
Pneumococcal (PCV)					
Meningococcal					
Hepatitis B					
Hepatitis A					
Varicella (Chicken pox)					
Human papillomavirus (HPV)					
Tuberculosis (Mantoux or PPD)					
Influenza (Flu)					
Tetanus (Td/TdaP)					
Other					

Tests	**Date**	**Results**	**Date**	**Results**	**Date**	**Results**
Lead test						
Other						
Other						

Anything you would like to add?

_____

_____

_____

Which family members, guardians, or other people are allowed to discuss your child's medical information with your doctor? You'll need to include them on the "HIPAA" privacy form your doctor gives you.

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

You should complete a new form at least once a year. For a new blank form, visit www.health.ny.gov/community/special_needs.