

# Emergency Information Form for Children With Autism

Last name:

American Academy of Pediatrics  
DEDICATED TO THE HEALTH OF ALL CHILDREN™



Date form completed	Revised	Initials
By Whom	Revised	Initials

Name:		Birth date:	Nickname:
Home Address:		Home/Work Phone:	
Parent/Guardian:	Emergency Contact Names & Relationship:		
Signature/Consent*:			
Primary Language:	Phone Number(s):		
Primary Means of Communication:	Does s/he wear a medical ID bracelet?		
<b>Physicians:</b>			
Primary care physician:		Emergency Phone:	
		Fax:	
Current Specialty physician:		Emergency Phone:	
Specialty:	Fax:		
Current Specialty physician:		Emergency Phone:	
Specialty:	Fax:		
Additional Specialty physician:		Emergency Phone:	
Specialty:	Fax:		
Anticipated Primary ED:		Pharmacy:	
Anticipated Medical Center:			

<b>Diagnoses/Past Procedures/Physical Exam:</b>	
1.	<b>Baseline vital signs:</b>
	Most recent height and weight (date):
2.	
3.	<b>Baseline neurological status:</b>
	Estimated age equivalent (date) for:
4.	Receptive language:
	Expressive language:
<b>Synopsis:</b>	Cognitive skills:
	Gross motor skills:
	Fine motor skills:
<b>Baseline physical findings:</b>	Comfort items:
	Does s/he tend to wander off?                      Where to?

\*Consent for release of this form to health care providers

Adapted from the ACEP/AAP Emergency Information Form for Children with Special Needs

<b>Diagnoses/Past Procedures/Physical Exam continued:</b>	
Medications:	Significant baseline ancillary findings (lab, x-ray, ECG):
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

<b>Management Data:</b>	
Allergies: Medications/Foods to be avoided	and why:
1. _____	_____
2. _____	_____
3. _____	_____
Procedures to be avoided	and why:
1. _____	_____
2. _____	_____
3. _____	_____

<b>Immunizations (mm/yy)</b>											
<b>Dates</b>						<b>Dates</b>					
DTaP						Hep B					
IPV						Varicella					
MMR						TB status					
HIB						Influenza					
Tdap						Pneumococcus					
Hep A						Meningococcus					
HPV						Rotavirus					

Antibiotic prophylaxis: \_\_\_\_\_ Indication: \_\_\_\_\_ Medication and dose: \_\_\_\_\_

<b>Common Presenting Problems/Findings With Specific Suggested Managements</b>		
Problem	Suggested Diagnostic Studies	Treatment Considerations

<b>Comments on child, family, or other specific medical issues:</b>	
Physician/Provider Signature: _____	Print Name: _____