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?	

Physicians:

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:	

Diagnoses/Past Procedures/Physical Exam:

1.	Baseline vital signs:
	Most recent height and weight (date):
2.	
3.	Baseline neurological status:
	Estimated age equivalent (date) for:
4.	Receptive language:
	Expressive language:
Synopsis:	Cognitive skills:
	Gross motor skills:
	Fine motor skills:
Baseline physical findings:	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

Last name:

Diagnoses/Past Procedures/Physical Exam continued:

Medications:	Significant baseline ancillary findings (lab, x-ray, ECG):
1.	
2.	
3.	
4.	
5.	
6.	

Management Data:

Allergies: Medications/Foods to be avoided	and why:
1.	
2.	
3.	
Procedures to be avoided	**and why:**
1.	
2.	
3.	

Immunizations (mm/yy)

Dates						Dates					
DTaP						Hep B					
IPV						Varicella					
MMR						TB status					
HIB						Influenza					
Tdap						Pneumococcus					
Hep A						Meningococcus					
HPV						Rotavirus					

Antibiotic prophylaxis: Indication: Medication and dose:

Common Presenting Problems/Findings With Specific Suggested Managements

Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:

Physician/Provider Signature: Print Name: