Your Child's Health Care Notebook

TRI-COUNTY HEALTH DEPARTMENT

This notebook belongs to:

_____

_____

_____

This is my story:

_____

_____

_____

_____

_____

_____

Our Promise

Promote the medical home approach to improve care outcomes.

How to use this notebook

This notebook can help you keep track of your child's health information.

When your child has special health needs, it's easy to feel overwhelmed. Your child may have lots of appointments with doctors and specialists. You may need special medical equipment and medicines to care for your child. This is a lot to keep up with.

This notebook will help you:

·Stay organized.
·Prepare for appointments.
·Share information with others.
·Be part of health care decisions.
·Be prepared in case of an emergency.

This is your notebook.
Organize the information in a way that works best for you.

To get started:

Look at the sections and pages in this notebook. Decide what information is most important.

Collect information that you already have:

·Reports from doctor visits.
·Important names and phone numbers.
·Lab and test results.
·Medicines.
·Vaccination (shot) records.
·Receipts for medical expenses.
·Equipment information.

Frequently Asked Questions

Q: Can I add other pages to this notebook?

A: This is your notebook and it should be useful for you. Feel free to add or remove any sections you want.

Q: What tips do you suggest to keep my child's health information organized?

A: Use your notebook for the most current information. Update your notebook after appointments. Move older information to another notebook or box.

Q: Should I bring my notebook to my child's appointments and medical center stays?

A: It's helpful to have your child's current information handy.

Q: What do I do with electronic information?

A: You may receive information from your doctor or specialist (provider) in email. You can print the information to put in this notebook.

Q: When do I need to update information?

A: Write down any changes in your child's care. It's hard to remember things like medicine changes or new providers.

My other questions:

Parents' guide to managing your child's health care

When your child gets a new diagnosis, it is important to learn all you can. You can help teach others who care for your child. Every child is special. They may have different needs and skills. This information reflects typical development.

For all ages:

- Get organized! Use a health care notebook or a smart phone health passport (app).
- Ask your doctors, nurses, and counselors questions. Write down what you learn.
- Download the patient portal app for your smart phone.
- Include your child in conversations about their health.
- Buy a medical alert bracelet or necklace for your child.
- Find local and national support groups.

Birth to 3 years old:

- Practice talking about your child's condition to your baby and a few people you and your family trust.
- Ask to meet other families who have a child with a similar condition.
- Teach your child the names of their body parts including their private parts.
- Keep a journal or write letters to your child about decisions you are making and what you are learning.

3 to 5 years old:

- Read storybooks about children with differences and special medical needs.
- Teach your child about their health and medicine. Create a daily schedule for medicines, therapies and hygiene.
- Involve your child in their daily care.
- Encourage your child to talk to doctors during appointments

5 to 10 years old:

- Be sure your child's phone has emergency contacts.
- Work with your child's school to create a legal 504 plan or individualized education plan (IEP).
- Give the school information about your child's condition. Teach them signs of an emergency. Have a plan for handling a health emergency at school.
- Teach your child to be aware of signs of pain, discomfort or changes in their body and when to tell an adult.
- Act out situations your child might have at school with classmates, teachers or in gym class. This will help your child practice how to answer questions about their medical condition.

10 to 14 years old:

- Teach your child about their medicine and what happens if they don't take their medicine.
- Teach your child how to use other supplies needed for their condition.
- Start a list of important words for your child to know about their health and medical condition.
- Let your doctors, nurses and social workers know what you are comfortable talking about with your child.
- Teach your child about puberty and what may be different about their experience. Schools often start education about puberty in 4th to 6th grade.
- Give your child books, websites and videos about their condition so they can read or watch by themselves.
- Encourage questions. Prepare your child to have one question for their doctor or nurse at every appointment

14 to 18 years old:

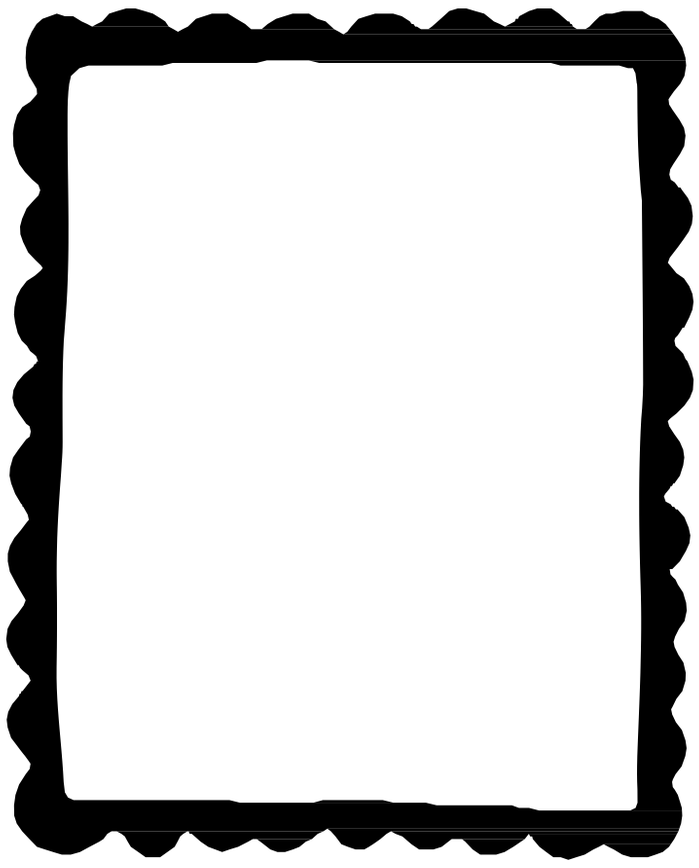
- Remind your child of their medical needs, names of conditions, surgical history and allergies.
- Teach your child how to order supplies, manage health insurance, schedule appointments and refill prescriptions.
- Tell your child about medical care and treatments they may need as they become adults.
- Start having your child plan their own schedule to include medicine, therapies and hygiene.
- Encourage your child to share their medical information with people they trust. This may be a friend, relative, therapist or teacher.
- Bring your child to groups where they can meet other kids with their condition.
- Request to meet an older person with your child's condition.
- Sex education usually begins in 6th grade. Talk with your child and your child's health care team about any medical needs that affect puberty, sex and intimacy.
- If your child cannot make their own medical decisions, apply for a medical power of attorney

18 and beyond:

- Provide support. Help your child become responsible for taking care of their own health needs as an adult.
- Help your child find doctors, therapists and specialists if your child is living away from home, going to college
or transferring to a doctor who treats adults.
- Help your child understand and plan for health insurance.

My Family and Personal Information

Photo of Me



Date:

My Name is: _____

My Nickname is: _____

I am _____Years Old

My Pet's Name is: _____

My Favorites

Toys: _____

Animal: _____

Games: _____

Hobbies: _____

Music: _____

TV Shows: _____

Other: _____

My Favorite Foods are: _____

My Least Favorite Foods are: _____

My Friends Name are: _____

When I am happy, I: _____

When I am sad, I: _____

When I feel pain, I: _____

Things I need help with (like washing, dressing, or brushing teeth): _____

Things I can do for myself (but thanks for asking): _____

If you need to know something else, ask me or ask: _____

_____

Reach them by calling: _____

Legal Guardian: _____
Address: _____
_____
Phone: _____
Mother's Name: _____
Address: _____
_____
Phone: _____
Email: _____
Father's Name: _____
Address: _____
_____
Phone: _____

Family Members

Sibling's Name: _____ Age: _____
Sibling's Name: _____ Age: _____
Sibling's Name: _____ Age: _____
Sibling's Name: _____ Age: _____

Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

Other Household Members

Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

Important Family Information

_____

_____

_____

_____

_____

Language Spoken at Home : _____
Other Language(s): _____
Interpreter Needed: Yes No
If Yes, Interpreter Name: _____
Phone: _____
Email: _____

Primary Emergency Contact

Name: _____

Relation: _____

Address: _____

_____

Daytime Phone: _____

Evening Phone: _____

Cell Phone: _____

Email: _____

Preferred Method to be Contacted: _____

Emergency Contact

Name: _____
Relation: _____
Address: _____
_____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____
Email: _____
Preferred Method to be Contacted: _____

Name: _____
Relation: _____
Address: _____
_____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____
Email: _____
Preferred Method to be Contacted: _____

Name: _____
Relation: _____
Address: _____
_____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____
Email: _____
Preferred Method to be Contacted: _____

Diagnosis and Conditions

This page helps you document your child's official and suspected diagnoses, along with the dates and other notes you may take about them.

Blood Type:

Diagnosis or Suspected Diagnosis	Provider Who Gave Diagnosis or Working on it	Date	Notes

Service Animal Information

Type of Service:

Psychiatric Service
Medical Alert and Response Service
Mobile/Physical Assistance Service
Emotional Support
Therapy

Type of Animal: _____

Animal's Name: _____

Support Animal Provides:

Diet and Nutrition

Dlet:

Special Feeding Instructions:

Normal Eating Times:

Foods to Avoid:

Food Allergies:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Tube Feeding							
Breakfast							
Lunch							
Dinner							
Snacks							

Tube Feeding Information

Type of Tube:

NG
Naso-intestinal
G-tube
J-tube
GJ-Tube

Delivery Method:

Syringe
Gravity
Feeding Pump

Tube Feedings:

Bolus or Intermittent
Continuous
Mix of two methods

Tube Size: _____
Pump Type: Infinity Pump Kangaroo Joey
How Often Fed: _____
Type of Formula: _____
Feed Rate mL/HR: _____
Amount of Feed (mL): _____
Date of Last Tube Change: _____
Next Time Tube Needs Changed: _____

Allergic Reaction Tracking Form

Date	Allergen	Reaction	Anecdote (w/Dosage)

Medical Information

Baseline Information

Blood Pressure: _____
Pulse/Heart Rate: _____
Respiratory Rate: _____
Respiratory Pattern: _____
Oxygen Saturation: _____
Temperature: _____
Appetite: _____

Temperament/Behaviors:

_____

_____

Activity:

_____

_____

Other:

_____

_____

_____

_____

Care Plan for Behavioral Disorders

Crisis Hotline: _____
Case Manager Phone: _____
Family Contact Person: _____
Phone: _____

What behavior pattern is typical for this individual? Include affect, seasonal changes etc. _____
_____
_____

Worrisome Behavior to Watch for: _____
_____
_____
Action Plan:
1. _____
2. _____
3.

Intermediate Dangerous Behavior: _____
_____
_____
Action Plan:
1. _____
2. _____
3. _____

Dangerous Behavior: _____
_____
_____
Action Plan:
1. _____
2. _____
3. _____

Extremely Dangerous Behavior: CALL 911

Care Plan for Medical Disorders

Physician Call Center Number: _____
Case Manager Phone: _____
Family Contact Person: _____
Phone: _____

What medical symptoms are typical for this individual? Include affect, behavioral problems, physical symptoms etc. of frequently occurring illnesses. _____
_____
_____

Worrisome Symptoms to Watch for: _____
_____
_____

Action Plan:
1. _____
2. _____
3.

Worsening Symptoms: _____
_____
_____

Action Plan:
1. _____
2. _____
3. _____

Dangerous Symptoms: _____
_____

Action Plan:
1. _____
2. _____
3. _____

Life Threatening Situations: CALL 911

Important Contact Information

Life-Threatening Emergency: Call 911

Primary Care Doctor- Medical Home

Name: _____
Address: _____

_____

Phone: _____
Fax: _____
Care Coordinator: _____
Email: _____

Urgent Care- After Hours - Advice Nurse

Name:
Address: _____

_____

Phone: _____
Fax: _____
Email: _____
Hours: _____

Primary Hospital

Name: _____
Address: _____

_____

Phone: _____
ER Phone: _____

Specialist Doctors-Therapists- Other Care Providers

Provider: _____
Specialty: _____
Clinic: _____
Address: _____
Phone: _____
Fax: _____
Hours: _____

Provider: _____
Specialty: _____
_____
Clinic: _____
Address: _____
Phone: _____
Fax: _____
Hours: _____

Provider: _____
Specialty: _____
_____
Clinic: _____
Address: _____
Phone: _____
Fax: _____
Hours: _____

Medical Equipment Supplier

Supplier: _____

Product: _____

_____

Contact: _____

Address: _____

Phone: _____

Fax: _____

Hours: _____

Supplier: _____

Product: _____

_____

Contact: _____

Address: _____

Phone: _____

Fax: _____

Hours: _____

Supplier: _____

Product: _____

_____

Contact: _____

Address: _____

Phone: _____

Fax: _____

Hours: _____

Community Agencies

Agency: _____

Service: _____

_____

Contact: _____

Address: _____

Phone: _____

Fax: _____

Hours: _____

Agency: _____

Service: _____

_____

Contact: _____

Address: _____

Phone: _____

Fax: _____

Hours: _____

Agency: _____

Service: _____

_____

Contact: _____

Address: _____

Phone: _____

Fax: _____

Hours: _____

Home Nursing Agencies

Agency: _____

Service: _____

Contact: _____

Address: _____

Phone: _____

Fax: _____

Hours: _____

Agency: _____

Service: _____

_____

Contact: _____

Address: _____

Phone: _____

Fax: _____

Hours: _____

Agency: _____

Service: _____

_____

Contact: _____

Address: _____

Phone: _____

Fax: _____

Hours: _____

Childcare Provider

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Email: _____

Hours: _____

Respite Care Provider

Name: _____

Address: _____

_____

Phone: _____

Fax:

Email: _____

Hours: _____

Pharmacy

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Email: _____

Hours: _____

Dentist-Orthodontist

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Email: _____

Hours: _____

Social Worker

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Email: _____

Hours: _____

Communication Notes

Date: _____

Time: _____

Communication Type (telephone, meeting, email)

_____

Name: _____

Agency: _____

Phone: _____

Reason _____

Notes

Growth Chart

Child's Name: _____Date of Birth: _____

Date	Age	Weight	Height	% Weight	% Height	% Ratio

What is a percentile?

A percentile shows how your child's height and weight compares to other children of the same age and sex. Height and weight are measured separately.

Example: If your son is in the 3oth percentile forweight, this means that 30 percent (or 30 out of 100) boys the same age weigh the same or less. This also means that 70 percent (or 70 out of100) boys weigh more .

Immunizations

Be sure your child's immunizations are up-to-date.

	Date	Date	Date	Date	Date	Date
Hep B						
Dtap						
Hib						
Polio						
PVC13						
RV						
MMR						
Varicella						
Hep A						
Flu						
Meningo coccal						
HPV						

Helpful Hint:

Ask your child’s primary care provider (PCP) for a copy of your child’s vaccine (shot) record.

Surgeries or Procedures

Date	Surgery/ Procedure	Surgeon/Specialist	Notes

Hospital Stays

Date	Reason	Doctor/s	Changes/Notes

Home Medicine List

1. Bring a current list of your child's medicines: Each time you go to the doctor, clinic, emergency room, etc.

2. Use your cell phone to keep track of medicines: Create a " medicine list" memo. You can take pictures of each medicine bottle. You can also try apps like MyMedSchedule or MediSafe meds and pill reminder for managing medicines.

3. If you fill prescriptions at a major pharmacy: You may be able to view medicine information through the pharmacy's website or mobile app.

Home Medicine List

Medicine	Strength	Dose	Route	Time	Reason	Last Taken

Durable Medical Equipment (DME)/Supplies

Name of Equipment: _____
Ordered by (provider): _____
Account # _____
Serial #/Model: _____
Description: _____
Supplier: _____
Product: _____
_____
Contact:_____
Address: _____
Phone: _____
Fax: _____
Hours: _____

Name of Equipment: _____
Ordered by (provider): _____
Account # _____
Serial #/Model: _____
Description: _____
Supplier: _____
Product: _____
_____
Contact:_____
Address: _____
Phone: _____
Fax: _____
Hours: _____

Helpful Hint:

Keep instruction manuals where you can find them.

Assistive Technology/Specialist Support Equipment/ Adaptive Devices

Assistive Device: _____

_____

_____

How to Use :

_____

_____

_____

When to Use:

_____

_____

_____

_____

Manufacturer:

_____

_____

_____

Contact Person: _____
Phone Number: _____
Address: _____
Date Purchased: _____

Port Line Information

Type of Implanted Port:

Single Lumen Port
Double Lumen Port
Power-Injectable Port

Date of Placement :

_____

_____

_____

Flush the Port with:

_____

_____

_____

_____

Does the patient need numbing medication before access

Yes
No:

Size of Needle Used to Access:

_____

Use the Port for (blood draws, medication, etc.):

_____

_____

PICC Line Information

Type of PICC Line:

Single Lumen
Double Lumen
Triple Lumen

Date of Placement :

Flush the PICC with:

How often to change the needleless connector:

How often to do a dressing change:

Use the line for (blood draws, medication, etc.):

PICC Line

Do not have any of the following on the arm where your PICC was placed:

-Needle sticks (such as for blood draws or an IV line).
-Blood pressure measurements.
-Tight clothing or tourniquets.

At least once a week, your:

-Tegaderm dressing, needleless connectors, and disinfection caps must be changed.
-PICC must be flushed.

Nebulizer and Vest Treatments

Date	TIme	Neb Given	Vest Given	02 Sat Pre	02 Sat Post	Intitals

Vest Settings and Treatment

Date Purchased: _____

Type of Vest:

Full Vest
Wrap Vest

Vest Size: _____
Frequency Settings: _____
Pressure Settings: _____
Minutes in Each Frequency: _____
Manufacturer of Vest: _____

Medications Used with Vest Treatment:

1) Bronchodilators:

_____

_____

2) Mucolytics:

_____

_____

3) Antibiotics:

_____

_____

Helpful Hint:

- To avoid problems with your child's stomach, try to do vest treatments before meals or no sooner than one hour after meals.

- Some patients find it helpful to moisten their airway secretions. This is done by taking nebulizer treatments with normal or hypertonic saline after other medicines are complete.

-If itching occurs, try a couple of cotton T-shirts between the skin and the vest.

- Have the vest machine and inflatable vest checked each year. This is needed to ensure it is working properly and that your child has the correct vest size.

Cough Assist Settings

Date Purchased: _____

Type of Device: _____

Manufacturer: _____

Mode:

Manual
Automatic

Expiratory Pressure: _____

Inspiratory Pressure: _____

Flow Rate: _____

Cycle Timing: _____

Suction Settings

Type of Suction:

Oropharyngeal
Nasopharyngeal

Type of Unit:

Wall Suction
Portable Suction

Suctioning Device:

Yankauer
Sterile Suction Catheter

Size of Sterile Suction Catheter: _____

Pressure Settings: _____

How long to Suction: _____

When to use Suction:

_____

_____

_____

_____

Ventilator Settings

Mode:

A/C
SIMV
CPAP
PSV
VS
CMV
APRV
MMV
IRV
HFOV

Tidal Volume: _____

Frequency (Respiratory Rate): _____

FiO2: _____

Inspiratory Flow Rate: _____

I:E Ratio: _____

Positive End Expiratory Pressure (PEEP): _____

Sensitivity: _____

Summary of Care Sensory and Communication

Vision

Clinic: _____
Ophthalmologist/Optometrist: _____
Date of First Visit: _____
Medical Record Number: _____
Address: _____
_____
Phone Number: _____
Email: _____
Website: _____

Date of Last Visit: _____
Results, if known: _____

Right Eye
Sphere: _____
Cylinder: _____
AXIS: _____
Prism: _____
Base: _____

Left Eye
Sphere: _____
Cylinder: _____
AXIS: _____
Prism: _____
Base: _____

Glasses
Contacts
Prosthesis
History of ROP (Retinopathy of Prematurity)
Surgery
Lasik
Other:

Other Comments or Pertinent Health Information: _____
_____
_____
_____

Summary of Care Sensory and Communication

Audiology/Hearing

Clinic: _____
Audiologist: _____
Date of First Visit: _____
Medical Record Number: _____
Address: _____
_____
Phone Number: _____
Email: _____
Website: _____

Date of Hearing Exam: _____
Results, if known: _____

Hearing Devices:
Cochlear Implant
Hearing Aids
Bone Conductive Device
Baha Band

Wears in:
Right Ear
Left Ear
Both Ears

Do they have a microphone that connects to hearing technology (DM/FM)?

Yes
No

Summary of Care Sensory and Communication

Cochlear Implant Information

External Unit of Cochlear Implant and Charger
Behind-the-ear external unit of Cochlear Implant

Brand: _____

Model: _____

Type of Battery: _____
MRI Compatibility/Limitations: _____

Do they have a microphone that connects to hearing technology (DM/FM)?

Yes
No

Brand of Microphone: _____

Model of Microphone: _____

Which Ear?

Right
Left
Both

Age at the time of Hearing Loss: _____
Cause of Hearing Loss: _____

Age at the time of Implants: _____

Purchase Date: _____
How are the devices stored: _____

Summary of Care Sensory and Communication

Hearing Aid Information

Brand: _____
Model: _____

Type of Battery: _____

Rechargeable?

Yes
No

Which Ear?

Right
Left
Both

Do they have a microphone that connects to hearing technology (DM/FM)?

Yes
No

Brand of Microphone: _____
Model of Microphone: _____

Purchase Date: _____
How are the devices stored: _____

Summary of Care Sensory and Communication

Bone Conduction Device

Brand: _____
Model: _____

Type of Battery: _____

Rechargeable?

Yes
No

If it is implanted, what are the MRI compatibilities/limitations?

_____

_____

Do they have a microphone that connects to hearing technology (DM/FM)?

Yes
No

Brand of Microphone: _____
Model of Microphone: _____

Purchase Date: _____
How are the devices stored: _____

Summary of Care Sensory and Communication

Speech and Communication

Clinic: _____
Speech & language pathologist: _____
Date of first visit: _____
Medical Record#: _____
Address: _____
Phone: _____
Fax: _____
Email: _____
Website: _____

Results of Evaluations:

_____
_____
_____
_____

Child uses following devices to meet communication needs:

□ Computer
□ Sign Language (ASL)
□ Communication Board
□ Interpreter Services
□ Lip Reads
□ Communication Book
□ Sign Language
□ Other:

Other comments or helpful information:

_____
_____
_____
_____

Summary of Care Sensory and Communication Catheterization Protocol

Type of Catheter:

Suprapubic
Intermittent
Indwelling (Urethra)

How Often to Cath:

_____

_____

_____

_____

When to Cath:

_____

_____

_____

_____

Size of Catheter: _____

Date Catheter was Changed: _____

Other Pertinent Information:

_____

_____

_____

_____

Catheterization Schedule

Date	TIme	Amount of Urine	Comment

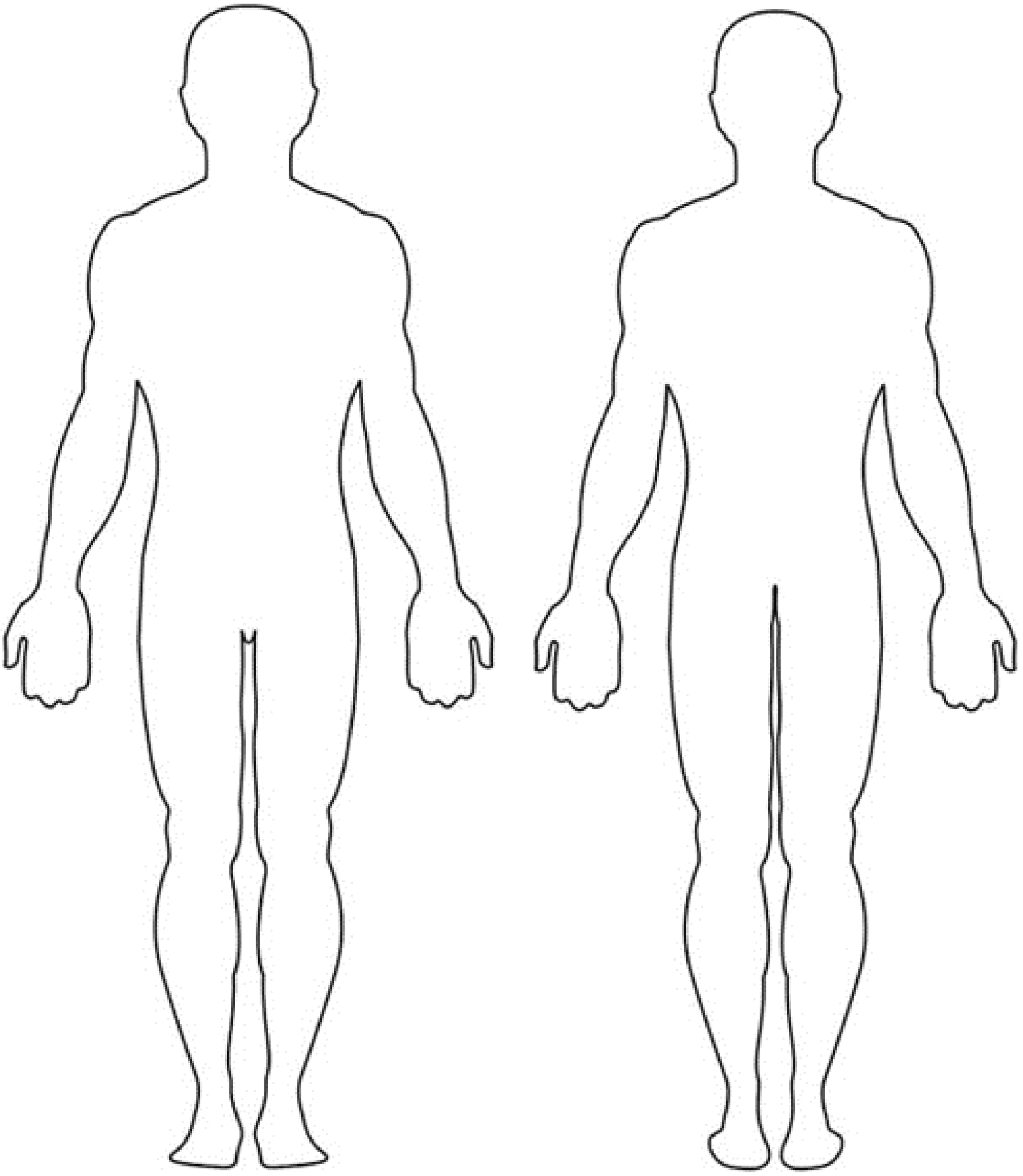
Seizure/Behavior Log

Date	Duration of Seizure	Description of Seizure or Behavior

Where Does it Hurt?

Mark each spot where you have an ache, pain, or discomfort, on the front and back.

Front **Back**




Wong-Baker Pain Rating Scale
0
2
4
6
8
10
No Hurt
Hurts Little Bit
Hurts Little More
Hurts Even More
Hurts Whole Lot
Hurts Worst

Insurance and Expenses

Medicaid is always secondary to any other insurance.

Medical Insurance Information

Primary Insurance: _____
Member ID: _____
Group Number: _____
Group Name/Employer: _____
_____
Subscriber's Name:
Date of Birth: _____
Subscriber's Phone: _____
Mailing Address: _____
_____
_____

Secondary Insurance: _____
Member ID: _____
Group Number: _____
Group Name/Employer: _____
_____
Subscriber's Name: _____
Date of Birth: _____
Subscriber's Phone: _____
Mailing Address: _____
_____
_____

Dental Insurance Information

Primary Insurance: _____
Member ID: _____
Group Number: _____
Group Name/Employer: _____
_____
Subscriber's Name:
Date of Birth: _____
Subscriber's Phone: _____
Mailing Address: _____
_____
_____

Secondary Insurance: _____
Member ID: _____
Group Number: _____
Group Name/Employer: _____
_____
Subscriber's Name: _____
Date of Birth: _____
Subscriber's Phone: _____
Mailing Address: _____
_____
_____

Vision Insurance Information

Primary Insurance: _____
Member ID: _____
Group Number: _____
Group Name/Employer: _____
_____
Subscriber's Name:
Date of Birth: _____
Subscriber's Phone: _____
Mailing Address: _____
_____
_____

Secondary Insurance: _____
Member ID: _____
Group Number: _____
Group Name/Employer: _____
_____
Subscriber's Name: _____
Date of Birth: _____
Subscriber's Phone: _____
Mailing Address: _____
_____
_____

Prescription Insurance Information

Primary Insurance: _____
Member ID: _____
Group Number: _____
Group Name/Employer: _____
_____
Subscriber's Name:
Date of Birth: _____
Subscriber's Phone: _____
Mailing Address: _____
_____
_____

Secondary Insurance: _____
Member ID: _____
Group Number: _____
Group Name/Employer: _____
_____
Subscriber's Name: _____
Date of Birth: _____
Subscriber's Phone: _____
Mailing Address: _____
_____
_____

Medical Bill Tracking Form

Date	Provider	Charges	Deductible	Primary Insurance Paid	Secondary Insurance Paid	Amount Owed /Date Paid

Helpful Hint:

Call your insurance provider if you have questions about bills.

Medical Bill Communication Log

Date	Provider	Date of Service	Service Provided	Date of Contact	Time/Name	Notes

Out of Pocket Expenses

Date	Activity (travel, mileage, lodging, supplies)	Amount

School Information

Preschool

School: _____

Address: _____

Principal: _____

Phone: _____

Teacher/Aide: _____

ST/PT/OT Name: _____

ST/PT/OT Phone:: _____

Kindergarten

School: _____

Address: _____

Principal: _____

Phone: _____

Teacher/Aide: _____

ST/PT/OT Name: _____

ST/PT/OT Phone:: _____

1st Grade

School: _____

Address: _____

Principal: _____

Phone: _____

Teacher/Aide: _____

ST/PT/OT Name: _____

ST/PT/OT Phone:: _____

School Information

2nd Grade

School: _____

Address: _____

Principal: _____

Phone: _____

Teacher/Aide: _____

ST/PT/OT Name: _____

ST/PT/OT Phone:: _____

3rd Grade

School: _____

Address: _____

Principal: _____

Phone: _____

Teacher/Aide: _____

ST/PT/OT Name: _____

ST/PT/OT Phone:: _____

4th Grade

School: _____

Address: _____

Principal: _____

Phone: _____

Teacher/Aide: _____

ST/PT/OT Name: _____

ST/PT/OT Phone:: _____

School Information

5th Grade

School: _____

Address: _____

Principal: _____

Phone: _____

Teacher/Aide: _____

ST/PT/OT Name: _____

ST/PT/OT Phone:: _____

6th Grade

School: _____

Address: _____

Principal: _____

Phone: _____

Teacher/Aide: _____

ST/PT/OT Name: _____

ST/PT/OT Phone:: _____

7th Grade

School: _____

Address: _____

Principal: _____

Phone: _____

Teacher/Aide: _____

ST/PT/OT Name: _____

ST/PT/OT Phone:: _____

School Information

8th Grade

School: _____

Address: _____

Principal: _____

Phone: _____

Teacher/Aide: _____

ST/PT/OT Name: _____

ST/PT/OT Phone:: _____

9th Grade

School: _____

Address: _____

Principal: _____

Phone: _____

Teacher/Aide: _____

ST/PT/OT Name: _____

ST/PT/OT Phone:: _____

10th Grade

School: _____

Address: _____

Principal: _____

Phone: _____

Teacher/Aide: _____

ST/PT/OT Name: _____

ST/PT/OT Phone:: _____

School Information

11th Grade

School: _____

Address: _____

Principal: _____

Phone: _____

Teacher/Aide: _____

ST/PT/OT Name: _____

ST/PT/OT Phone:: _____

12th Grade

School: _____

Address: _____

Principal: _____

Phone: _____

Teacher/Aide: _____

ST/PT/OT Name: _____

ST/PT/OT Phone:: _____

Transition Year

School: _____

Address: _____

Principal: _____

Phone: _____

Teacher/Aide: _____

ST/PT/OT Name: _____

ST/PT/OT Phone:: _____

School Information

Transition Year

School: _____

Address: _____

Principal: _____

Phone: _____

Teacher/Aide: _____

ST/PT/OT Name: _____

ST/PT/OT Phone:: _____

Transition Year

School: _____

Address: _____

Principal: _____

Phone: _____

Teacher/Aide: _____

ST/PT/OT Name: _____

ST/PT/OT Phone:: _____

Transition Year

School: _____

Address: _____

Principal: _____

Phone: _____

Teacher/Aide: _____

ST/PT/OT Name: _____

ST/PT/OT Phone:: _____

Insert a copy of your child's current IEP.

This should include a Transition Plan at the age of 14.

If you do not use an IEP then add your Section 504 and/or Individualized Health Plan (IHP) plan to this section.

Insert a copy of legal papers (custody, guardianship, or advanced directive forms).

Letter Log

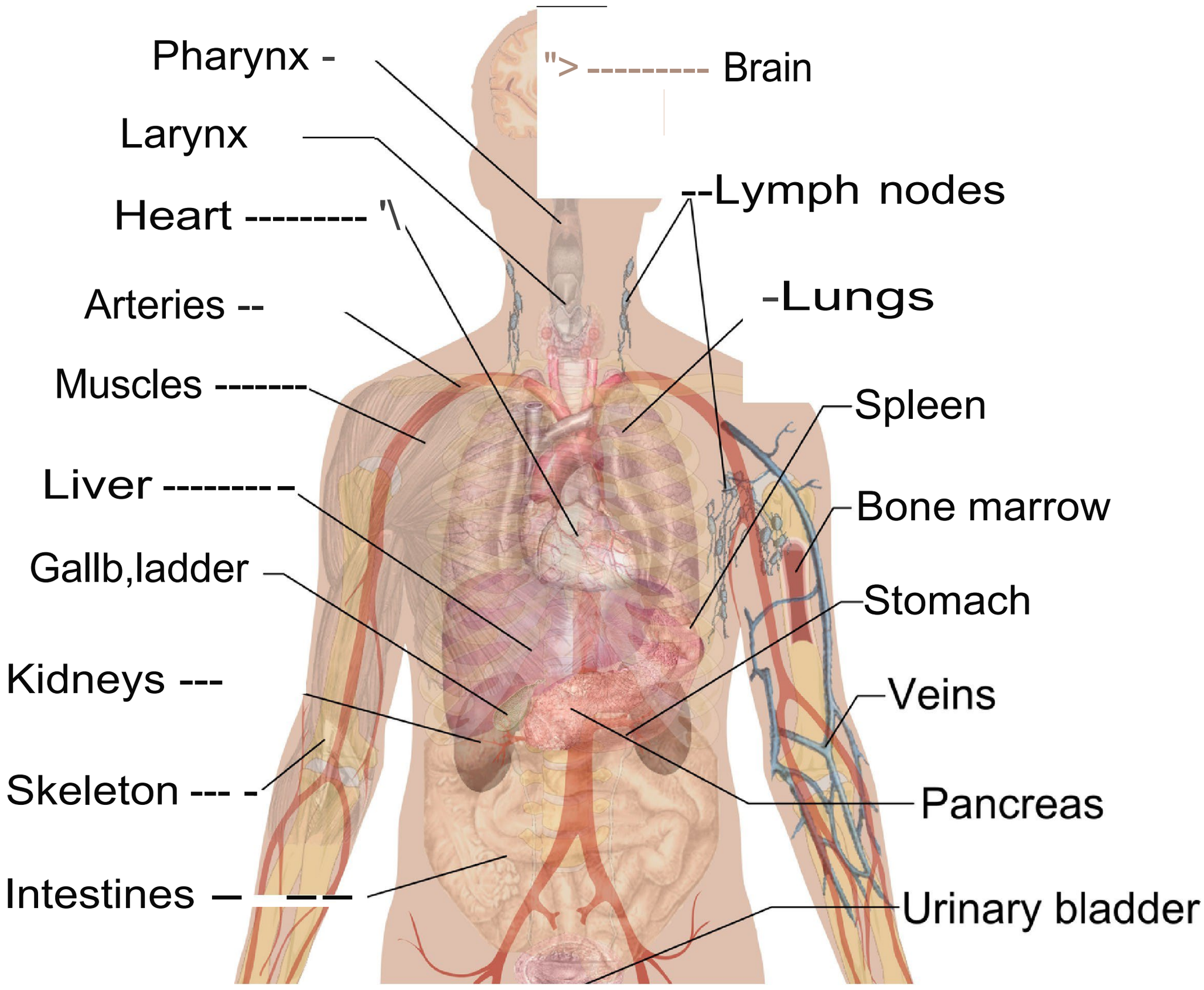
Date	To Whom	From Whom	Reason for Letter	Reply

Telephone Log

Date	Time	Person Called	Reason	Follow-Up

Body Map and Words to Know

Internal organs



Important Words to Know

Allergist -A doctor who diagnoses and treats allergies.

Anesthesiologist -Gives medicine before and during surgery to help patients relax, fall asleep and stay asleep through the operation.

Benefits -Health care items or services that can be paid for by a healtl1 insurance plan. Health insurance providers, Medicaid and CHIP provide information about what benefits are offered by their plans.

CHIP -Children's Health Insurance Program provides no cost or low-cost health coverage. It may be a choice for families who make too much to qualify for Medicaid. Each state has its own rules about who qualifies for CHIP.

Chronic -A medical condition that may last for a lifetime. There are times when the illness gets worse or better. A chronic illness usually can be managed, but not cured.

Claim -A request to an insurance provider to pay for medical care or supplies.

Clinical therapist -A licensed professional that offers emotional and behavioral support for patients with primary medical conditions.

Coinsurance -An amount that you may have to pay as your share of the cost for services, after you pay any deductibles. It is usually expressed as a percentage.

Important Words to Know

Co-payment -An amount that you pay as your share of the cost for a medical service or supply, like a doctor's visit or a prescription. A co-payment is usually a set amount like $10 or $20. This amount is set by your insurance provider.

Complete Care -When your child sees several specialists who work together to treat your child.

Compounding pharmacy -A special pharmacy that has a license to make a medicine just for a certain person. The pharmacy may make a liquid form of a medicine or mix several medicines to make a special strength or dose.

Deductible -The amount of money that you will have to pay out of your own pocket for health care before your health insurance plan will begin to pay any costs.

Different plans have different deductible amounts.
There are some costs that your insurance may pay before you have met your deductible.
There are some costs that may not count toward meeting your deductible.

Dermatologist -A doctor who treats skin, hair, and nails.

Developmental pediatrician -A medical doctor who has specia training to diagnose and treat children with development or behavior problems.

Important Words to Know

Diagnostic tests - Tests and procedures ordered by a health care provider to see if a person has a condition or disease.

Durable medical equipment (DME) - Something that is needed because of a medical condition. It is equipment that can be used over and over. It is ordered by your primary care provider. Some examples of durable medical equipment are hospital beds and respirators.

Endocrinologist - A doctor who specializes in diagnosing and treating conditions caused by hormone problems and the glands that make hormones. Diabetes and growth problems are treated by an endocrinologist.

Growth chart - Gives you an idea of how your child is developing. You can see how your child has grown.

Hematologist - A doctor who specializes in blood disorders.

Hospitalist - A doctor who takes care of people when they are in the hospital.

Immunizations - Medicines (shots)that are given to your child to prevent illnesses. Primary care providers usually give these shots to your child is at certain ages. These are also called vaccinations.

Immunologist - A doctor who diagnoses and manages disorders of the immune system.

Important Words to Know

Infectious disease specialist - A doctor or specialist who diagnoses and treats infections.

In-network - A provider who works with your health insurance or plan and offers services at a discounted rate.

Neonatologist - A doctor who takes care of premature and critically ill newborn babies.

Neuropsychologist - A doctor who understands how the brain works and assesses and treats patients with brain injury or disease.

Nurse practitioners (NP, CPNP) - Work with doctors and the health care team to diagnose and treat your child. Nurse practitioners have special medical training to get certified and licensed. They can give a diagnosis and write prescriptions for medicines and other treatments.

Occupational therapist (OT) - An occupational therapist works with patients to improve coordination, motor skills and skills needed to play, function in school, and perform routine activities (like hand-eye coordination).

Oncologist - A doctor who specializes in diagnosing and treating cancer.

Out of network - A provider who does NOT work with your health insurance or plan. If you choose an out-of-network provider, your insurance may not pay as much or may not pay at all for those services.

Important Words to Know

Out-of-pocket costs - Costs that you will have to pay for yourself because they are not covered by your insurance. Out-of-pocket costs include deductibles, coinsurance, and co payments. Sometimes you can deduct these expenses from your taxes.

Over the counter - Drugs and supplies that can be bought without a prescription.

Pain management specialist - A pain management specialist is a doctor with knowledge and training in diagnosing and treating pain

Pathologist - A doctor who studies body fluids and tissues to help find a diagnosis.

Pediatrician - A doctor who takes care of babies, children, and teens.

Pharmacist - Provides medicines for patients, checks for any interactions between drugs and works with the medical team to choose the
best medicine.

Physical therapist (PT) - A physical therapist uses exercises, stretches and other techniques to improve mobility, decrease pain and reduce any disability related to illness or injury.

Physician assistant (PA) - A nationally certified and state-licensed medical professional. They practice medicine on healthcare teams with doctors and other providers.

Important Words to Know

Primary care provider (PCP) - The health care provider your child goes to for medical care like checkups, vaccinations, and minor illnesses. This person can also refer your child to a specialist when necessary.

Primary insurance - Also called primary coverage. If you have more than one health insurance plan, this is the insurance plan t11at pays any claims first.

Procedure - A medical treatment or operation done to diagnose, measure or treat a problem such as a disease or injury.

Provider - A doctor, hospital health care professional or health care facility.

Psychiatrist - A medical doctor who specializes in treating emotional and behavioral problems through psychotherapy, prescribing medications and performing some medical procedures.

Psychologist - A psychologist specializes in treating emotional and behavioral problems through psychological consultation, assessment, testing and therapy.

Qualify - An event or condition that allows you to get a benefit or service.

Radiologist - A specialist who diagnoses and treats diseases and injuries using medical imaging techniques, such as X-rays, computed tomography (CT) and magnetic resonance imaging (MRI).

Important Words to Know

Referral - An order from your primary care provider for your child to see a specialist. Some insurance plans will not pay for services from a specialist unless you get a referral first.

Respiratory therapist (RT) - Evaluates, treats and cares for breathing problems and heart problems that can also affect the lungs.

Rheumatologist - A doctor who treats problems involving the joints, muscles, and bones, as well as autoimmune diseases. Rheumatologists treat conditions such as arthritis and lupus.

Secondary insurance - If you have more than one health insurance plan, this plancovers costs that are left over after the primary insurance pays its share.

Services - Health care that is given by a provider. This includescare for keeping your child healthy,as well as treating an illness, injury, or condition.

Sleep specialist - A doctor who specializes in diagnosing and treating sleep disorders.

Specialist - A health care provider who is trained to provide care in a special medical field. For example, a cardiologist is a person who has extra training in caring for heart problems.

Speech-language pathologist (SLP)-Specially trained and certified to treat many types of communication, swallowing and feeding problems.

Important Words to Know

Surgeon - A doctor who performs operations.

Therapist - Someone who works with a patient who has special needs because of an illness or injury. There are different kinds of therapists including speech, occupational, physical, and respiratory.

Urologist - A doctor who treats the urinary system, including conditions of the urethra, bladder, ureters, kidneys, and genitals.

Vaccinations - See Immunizations

Acronym Index

ADA	Americans with Disabilities Act
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
AIDS	Acquired Immune Deficiency Syndrome
ARC	The ARC: Advocates for the Rights of Citizens with Developmental Disabilities and their Families
ARNP	Advanced Registered Nurse
BIA	Bureau of Indian Affairs
BD	Behaviorally Disabled
CAP-C	Community Alternatives Program for Children
CAP-MR/DD	Community Alternatives Program for Mentally Retarded/Developmentally Disabled Individuals
CD	Communication Disorders
CDS	Communication Disorders Specialist
CFR	Code of Federal Regulations
CHRMC	Children's Hospital and Regional Medical Center
CP	Cerebral Palsy
CPS	Child Protective Services
CSHCN	Children with Special Health Care Needs
CSO	Community Service Office, DSHS
DCFS	Division of Children and Family Services
DD	Developmentally Disabled
DDD	Division of Developmental Disabilities
DSHS DDPC	Developmental Disabilities Planning Council
DH	Developmentally Handicapped
DMH	Division of Mental Health
DH	Department of Health
DSB	Department of Services for the Blind
DSHS	Department of Social and Health Services
DVR	Division of Vocational Rehabilitation
ECDAW	Early Childhood Education and Assistance Program
ED	Emotionally Disturbed
EEG	Electroencephalogram
EFMP	Experimental Education Unit, CHDD Exceptional Family Member Program (helps military families locate to areas with services)

Acronym Index

EKG	Electrocardiogram
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
ESD	Educational Service District
FAPE	Free Appropriate Public Education
FRC	Family Resources Coordinator
HHS	Health and Human Services
HI	Health Impaired or Hearing Impaired
HMO	Health Maintenance Organization
HO	Healthy Options, DSHS, Medicaid Managed Care
HOH	Hard of Hearing
ICC	Interagency Coordinating Council; county ICC and state ICC.
IDD	Intellectual Developmentally Disability
IDEA	Individuals with Disabilities Education Act
IEP	Individual Education Plan
IFSP	Individual Family Service Plan
I& R	Information and Referral
ISP	Individual Service Plan
LD	Learning Disabled
LDA	Learning Disabilities Association
LEA	Local Education Agency
LICWAC	Local Indian Child Welfare Advocacy Board
LRE	Least Restrictive Environment
MCH	Maternal and Child Health
MD	Medical Doctor
MDT	Multi-Disciplinary Team
MH	Multiply Handicapped
MR	Mentally Retarded
MR/DD	Mentally Retarded/Developmentally Disabled
MS	Multiple Sclerosis

Acronym Index

NICU	Neonatal Intensive Care Unit
NORD	National Association of Rare Disorders
OCR	Office of Civil Rights
OFM	Office of Financial Management
OI	Orthopedically Impaired
OSEP	Office of Special Education Programs
OSERS	Office of Special Education and Rehabilitation Services
OSPI	Office of Superintendent of Public Instruction
OT	Occupational Therapy/Therapist
OTR	Licensed and Registered Occupational Therapist
PAVE	Parents Are Vital in Education
P & A	Protection and Advocacy
PHN	Public Health Nurse
PL	Public Law
PT	Physical Therapy/Therapist
PTA	Parent Teacher Association
RN	Registered Nurse
RPR	Registered Physical Therapist
SBD	Seriously Behaviorally Disabled
SEA	State Education Agency
SEAC	Special Education Advisory Council
SEPAC Council	Special Education Parent/Professional Advisory
SLD	Specific Learning Disability
SSA	Social Security Administration
SSI	Social Security Income
STOMP	Specialized Training of Military Parents
SW	Social Work/Worker
TANF	Temporary Assistance to Needy Families
TAPP	Technical Assistance for Parents and Professionals
TASH	The Association for Persons with Severe Handicaps
TBI	Traumatic Brain Injury
TDD	Telecommunication Device for the Deaf
TRICARE	U.S. Department of Defense Health Care System
TTY	Telecommunication Device for Deaf, Hearing, Impaired, and Speech Impaired Persons
VI	Visually Impaired
WIC	Women, Infants and Children Supplemental Food Program

This list was adapted from and used with permission of PAVE.

Attachments

MhMil oo Allergy
ooaoo n of America | www.aafa.org/AnaphylaxisInAmerica

Sample Anaphyla•x s Emergency Ac io Plan

NAM . _____ AiGI:_____

ALLERGY TO: _____

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†*Adapted from J Allergy Clin Immunol 1998;102:173–176 and J Allergy Clin Immunol 2006;117:367–377.*

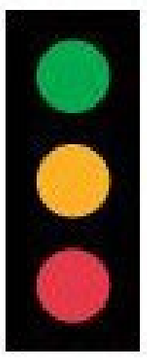
@ https://aafa.org/allergies/allergy-symptoms/anaphylaxis-severe-allergic-reaction/

ASTHMA ACTION PLAN

Asthma and Allergy Foundation of America
aafa.org

Name:	Date:
Doctor:	Medical Record #:
Doctor's Phone #: Day	Night/Weekend
Emergency Contact:	
Doctor's Signature:	

The colors of a traffic light will help you use your asthma medicines.



GREEN means Go Zone!
Use preventive medicine.

YELLOW means Caution Zone!
Add quick-relief medicine.

RED means Danger Zone!
Get help from a doctor.

Personal Best Peak Flow: _____

GO

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work & play

Peak flow: from _____ to _____

Use these daily controller medicines:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
For asthma with exercise, take:		

CAUTION

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

Peak flow: from _____ to _____

Continue with green zone medicine and add:

MEDICINE	HOW MUCH	HOW OFTEN/ WHEN
CALL YOUR ASTHMA CARE PROVIDER.		

DANGER

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Trouble speaking
- Ribs show (in children)

Peak flow: reading below _____

Take these medicines and call your doctor now.

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Your doctor will want to see you right away. It's important!
If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.
Make an appointment with your asthma care provider within two days of an ER visit or hospitalization.

https://aafa.org/asthma/asthma-treatment/asthma-treatment-action-plan/

TODAY'S HEALTH CARE VISIT

COMPLETE BEFORE THE VISIT

My Name: _____

Today's Date: _____

Who is with me today? _____

Current list of my medications, pills, and vitamins
(attach it for the doctor or nurse)

Do I have a plan or card that pays for my medicine?
Yes / No (list) _____

Did I recently go see any other doctor or dentist?
Yes / No (who?) _____

What was the reason? _____

Why am I at the doctor's or clinic today?

(Things like illness, check-up, follow-up from previous visit, need forms filled out, need medication change or refill, etc.)

QUESTIONS I WANT TO ASK TODAY	ANSWERS TO MY QUESTIONS

MY TAKE-AWAY INFORMATION

Were there any Medication or Diet Changes?
YES / NO *If yes:*

Medication Name: _____
I am to take this ____ times per day, at _____
I am to stay on this for ____ days (or specify _____)
Why do I need to take this? _____

Medication Name: _____
I am to take this ____ times per day, at _____
I am to stay on this for ____ days (or specify _____)
Why do I need to take this? _____

Are there medications I don't need to take anymore, or anything else I should know?

Information about today's treatment plan, recommendations, and/or follow-up

(Things like illness, check-up, follow-up from previous visit, need forms filled out, need medication change or refill, etc.)

medical professional signature date

staff or provider signature date

https://www.lifecoursetools.com/lifecourse-library/exploring-the-life-domains/healthy -living/

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION

Name: _____ **Birth Date:** _____

Address: _____ **Phone:** _____

Emergency Contact/Relationship: _____ **Phone:** _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply)

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify emergency contact
- ☐ Notify emergency contact at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First Aid for any seizure

- ☐ **STAY** calm, keep calm, begin timing seizure
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

When and What to do

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

epilepsy.com

 Revised 03/2023 1SOSRP/PA87216

https://www.epilepsy.com/sites/default/files/2023-08/SeizureActionPlan2023ACCE.pdf

Seizure Action Plan *continued*

Care after seizure

What type of help is needed? (describe) _____

When is person able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History: _____

Allergies: _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy: ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature: _____ Date _____

Provider Signature: _____ Date: _____

EPILEPSY FOUNDATION

https://www.epilepsy.com/sites/default/files/2023-08/SeizureActionPlan2023ACCE.pdf

Wound Assessment form

Date: _____ Patient Name: _____ Patient ID: _____

Patient

Age: _____ years

Weight: _____ kgs

Gender: ☐ Male ☐ Female

Nutrition status: ☐ Well nourished ☐ Malnourished

Mobility status: ☐ Good mobility ☐ Bad Mobility

Smoking: ☐ Yes ☐ No

If yes, how many/day: _____

Alcohol: _____ units/week

Co-morbidities: _____

_____

_____

Medications: _____

ABPI (*if done*): _____ Date: _____

Wound description

Wound type: _____

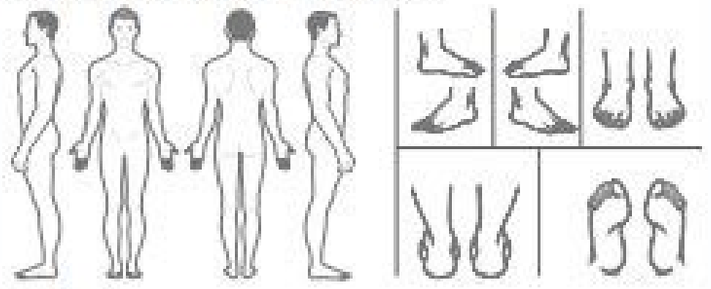
Duration of wound: _____

Previous treatments: _____

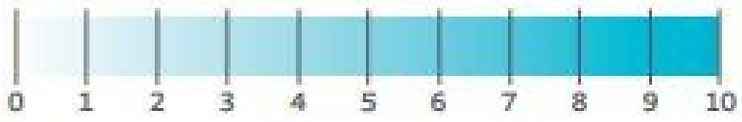
_____

Size: length ____mm width ____mm depth ____mm

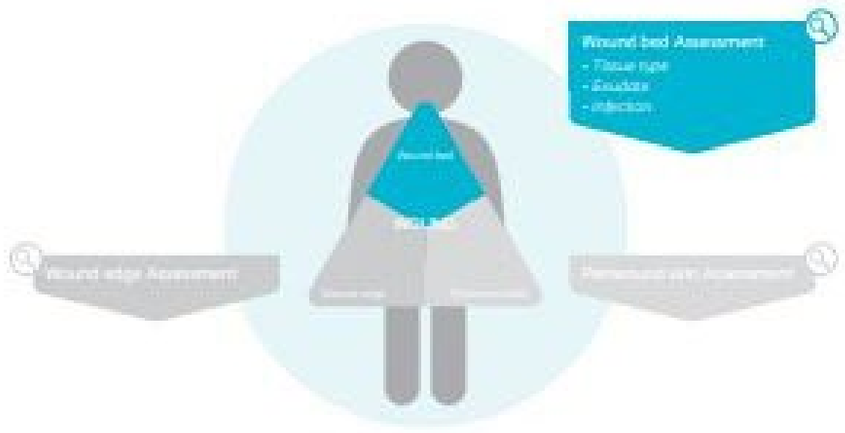
Wound location (please circle wound):



Pain level:



Wound bed assessment



Wound bed Assessment

Tissue type

Necrotic ☐ —— % Granulating ☐ —— %

Sloughy ☐ —— % Epithelialising ☐ —— %

Exudate

Level ☐ Dry ☐ Low ☐ Medium ☐ High

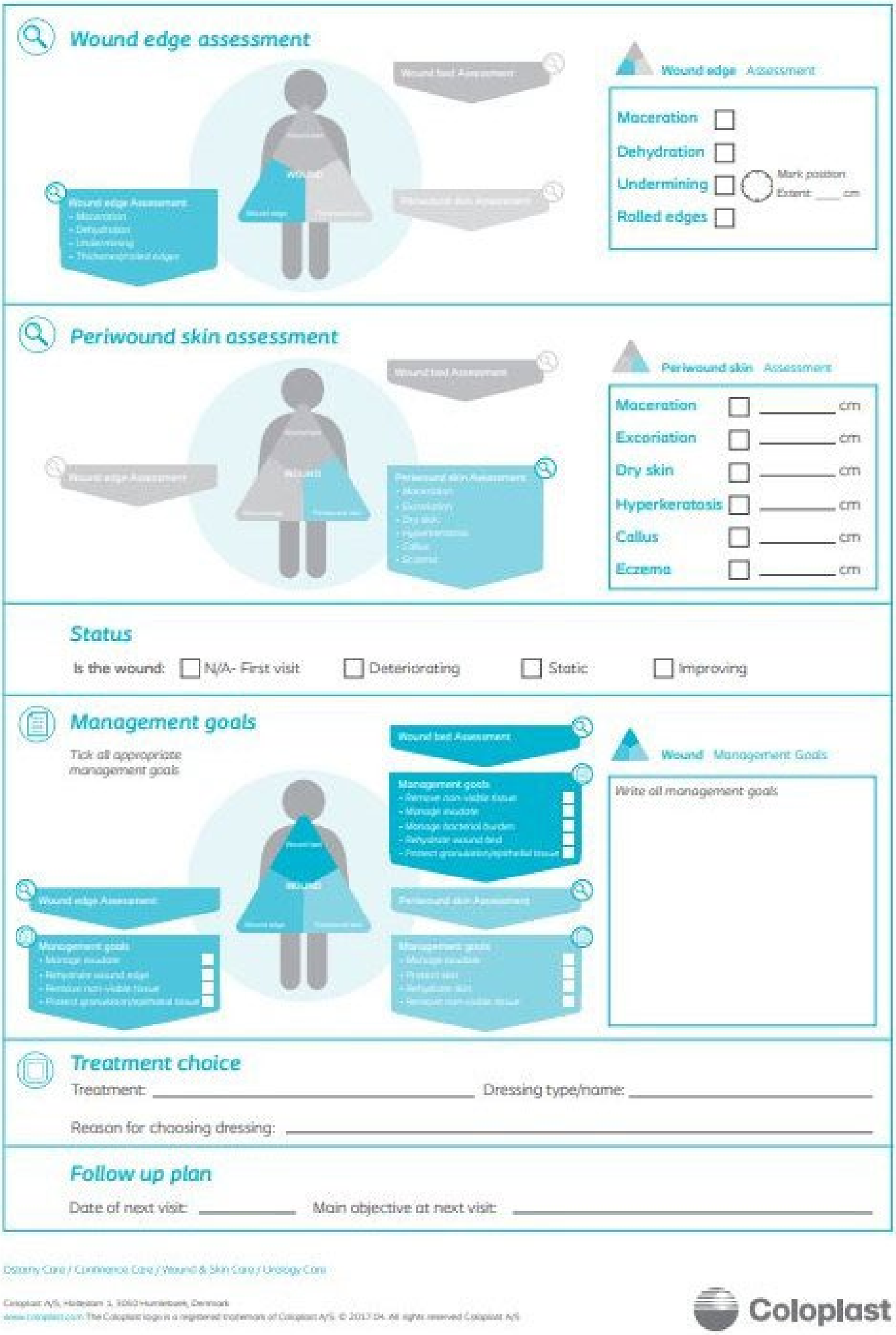
Type ☐ Thin/watery ☐ Cloudy ☐ Thick ☐ Purulent ☐ Clear ☐ Pink/red

Infection

Local	Spreading/systemic
☐ Increased pain	☐ Increased erythema
☐ Erythema	☐ Pyrexia
☐ Oedema	☐ Abscess/pus
☐ Local warmth	☐ Wound breakdown
☐ Increased exudate	☐ Cellulitis
☐ Delayed healing	☐ General malaise
☐ Friable granulation tissue	☐ Raised WBC count
☐ Malodour	☐ Lymphangitis
☐ Pocketing	

Coloplast

https://www.coloplast.com/Global/1_Corporate_website/Products/Woundcare/TOWA/CPWSC_EWMA%202017_TOWA_Wound%20assesment_Onepager%20A4_no%20marks.pdf



https://www.coloplast.com/Global/1_Corporate_website/Products/Woundcare/TOWA/CPWSC_EWMA%202017_TOWA_Wound%20assesment_Onepager%20A4_no%20marks.pdf

Daily Central Line Maintenance Checklist – Template

Patient Name/ID#: _____ **Unit:** _____ **Room/Bed:** _____

Date: _____

Person Completing Form: Name _____

Date of initial line placement: _____

Date implanted port accessed: _____

Date injection caps last changed: _____

Date administration set and add-on devices last changed: _____

Set used for: Continuous Infusion ☐ Intermittent Infusion ☐

Date dressing last changed: _____ **Dressing type:** Gauze ☐ Clear ☐

Critical Steps	Yes	No	N/A	Notes/Comments
Necessity assessed If no longer necessary, remove, indicating details of removal in the records (including date, location, and signature and name of operator undertaking removal).				
Injection sites are covered by caps or valved connectors				
Caps changed today				
Implanted ports newly accessed today				
Accessed with (indicate type and size of needle)				
Insertion site without evidence of infection				
Dressing intact and labeled properly				
Dressing changed today				
Catheter stabilized/no tension on line				
Administration set replaced and labeled this time?				

Procedural Reminders

Suspected Infection

- If central venous catheter infection is strongly suspected, replace catheter and all intravenous fluids, tubing, and caps.

Hand Hygiene

- Clean hands immediately before and after each episode of patient contact using the correct hand hygiene technique. (Use World Health Organization "My 5 Moments for Hand Hygiene".)

Cap Changes

- Sanitize caps with 2%chlorhexidine gluconate in 70% isopropyl alcohol before and after each use ("Scrub the Hub").
- Change caps when necessary using sterile gloves and mask, that is, after administering blood and if there is visual observation of blood in the caps.
- Change caps no more often than 72 hours (or according to the manufacturer's recommendations and whenever the administration set is changed).

Tubing Changes

- Replace administration sets and add-on devices no more frequently than every 96 hours, and at least every 7 days, after initiation of use, unless contamination occurs.
- Replace set and add-on devices within 24 hours of start of infusion if fluids that enhance microbial growth are infused (for example, fat emulsions combined with amino acids and glucose in three-in-one admixture or blood products infused separately).
- Change needleless components as often as the administration set and no more often than 72 hours.

Dressing Changes

- Change gauze dressing every 2 days, clear dressings every 7 days, unless dressing becomes damp, loosened, or visibly soiled then change.
- Use sterile gauze or sterile, transparent, semipermeable dressings.
- Perform catheter site care using 2% chlorhexidine gluconate in 70% isopropyl alcohol to clean the insertion site during dressing changes.

https://www.jointcommission.org/-/media/tjc/documents/resources/health-services-research/clabsi-toolkit/clabsi_toolkit_tool_3-23_daily_central_line_maintenance_checklist_-_templatepdf.pdf

Helpful Websites

http://www.aap.org/
American Academy of Pediatrics

www.HealthyTransitionsNY.org
For youth with developmental disabilities ages 14-25, family caregivers, service coordinators, and health care providers. It teaches skills and provides tools for care coordination, keeping a health summary, and setting priorities during the transition process. It features video vignettes that demonstrate health transition skills and interactive tools that foster self-determination and collaboration.

http://medicalhomeinfo.org/
Provides resources for health professionals, families, and everyone interested in creating a family-centered medical home for all children and youth.

Other versions of care notebooks and helpful forms can be downloaded at: www.cshcn.org

Information on care notebooks & emergency preparedness
www.FullLifeAhead.org

Citations

https://aafa.org/allergies/allergy-symptoms/anaphylaxis-severe-allergic-reaction/

https://www.coloplast.com/products/wound/triangle/

https://aafa.org/asthma/asthma-treatment/asthma-treatment-action-plan/

https://www.lifecoursetools.com/lifecourse-library/exploring-the-life-domains/healthy -living/

https://www.epilepsy.com/local/missouri-kansas

https://www.jointcommission.org/-/media/tjc/documents/resources/health-services-research/clabsi-toolkit/clabsi_toolkit_tool_3-23_daily_central_line_maintenance_checklist_-_templatepdf.pdf

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TRI-COUNTY HEALTH DEPARTMENT