

PAGE 1 Date completed _____

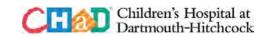




CHILD'S NAME: _____ DATE OF BIRTH: _____ AGE: _____ HEIGHT: _____ WEIGHT: ____ CHILD'S NICKNAME: ADDRESS AND CONTACT INFORMATION Parents/Guardians: _____ Relationship: _____ Cell phone: ____ Home phone: _____ Primary language/Communication: Important things to know about my child: **MEDICAL INFORMATION** Age when diagnosed: _____ Diagnosis (es): ______ Age when diagnosed: Age when diagnosed: _____ ALLERGIES/SENSITIVITIES Reactions ALLERGIES/SENSITIVITIES Reactions **MEDICATIONS** Dose Time **OTC Medications/Supplements**



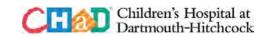




HEALTHCARE AND OTHER PROVIDERS		
Primary Care Provider:		Phone:
		Fax:
Specialty Provider:		Phone:
		Fax:
Specialty Provider:		Phone:
		Fax:
Other Provider:		Phone:
		Fax:
Other Provider:		Phone:
HOSPITALIZATIONS		
Date Surgeries/Procedures/Illnesses	;	Hospital/Doctor
MEDICAL EQUIPMENT/SUPPLIES	Provider	Contact Info.
HEALTH INSURANCE - PRIMARY	HEALTH INSURANCE - SECONDARY	
Name:	Name:	
Group #:	Group #:	
ID #:	ID #:	
Phone:	Phone:	
Fax:	Fax:	
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GETTING TO KNOW MY CHILD	
NAME:	NICKNAME:
DATE OF BIRTH:	TODAY'S DATE:
A little about my child	
My child's strengths (things that are easy for my child)	
My child's challenges (examples: communication, feeding, lea	rning, mobility, socialization, energy, behavior)
My child's life in the community (examples: school, childcan	e, place of worship, favorite places)
Ways you can help my child (examples: speak quietly, give	choices, do not talk about scary things)
Things to avoid (examples: food, activities, and procedures)	
Other important information	Tip: Keep laminated copies of
	the Portable Medical Summary

the Portable Medical Summary on hand, or take a picture and keep a copy on mobile devices.