



Medical Summary and Emergency Care Plan

This document should be shared with and carried by youth and families/caregivers.

| | | | |
|---|---------|-------------------------------------|--------------------------|
| Date Completed: | | Date Revised: | |
| Form completed by: | | | |
| Contact Information | | | |
| Name: | | Nickname: | |
| DOB: | | Preferred Language: | |
| Parent (Caregiver): | | Relationship: | |
| Address: | | | |
| Cell #: | Home #: | Best Time to Reach: | |
| E-Mail: | | Best Way to Reach: Text Phone Email | |
| Health Insurance/Plan: | | Group and ID #: | |
| Emergency Care Plan | | | |
| Emergency Contact: | | Relationship: | Phone: |
| Preferred Emergency Care Location: | | | |
| Common Emergent Presenting Problems | | Suggested Tests | Treatment Considerations |
| | | | |
| | | | |
| Special Concerns for Disaster: | | | |
| Allergies and Procedures to be Avoided | | | |
| Allergies | | Reactions | |
| | | | |
| | | | |
| | | | |
| To be avoided | | Why? | |
| <input type="checkbox"/> Medical Procedures: | | | |
| <input type="checkbox"/> Medications: | | | |
| Diagnoses and Current Problems | | | |
| Problem | | Details and Recommendations | |
| <input type="checkbox"/> Primary Diagnosis | | | |
| <input type="checkbox"/> Secondary Diagnosis | | | |
| <input type="checkbox"/> Behavioral | | | |
| <input type="checkbox"/> Communication | | | |
| <input type="checkbox"/> Feed & Swallowing | | | |
| <input type="checkbox"/> Hearing/Vision | | | |
| <input type="checkbox"/> Learning | | | |
| <input type="checkbox"/> Orthopedic/Musculoskeletal | | | |
| <input type="checkbox"/> Physical Anomalies | | | |
| <input type="checkbox"/> Respiratory | | | |
| <input type="checkbox"/> Sensory | | | |
| <input type="checkbox"/> Stamina/Fatigue | | | |
| <input type="checkbox"/> Other | | | |



Sample Medical Summary and Emergency Care Plan

Six Core Elements of Health Care Transition 2.0

| School and Community Information | | | |
|--|---------------------|--------------|------|
| Agency/School | Contact Information | | |
| | Contact Person: | Phone: | |
| | Contact Person: | Phone: | |
| | Contact Person: | Phone: | |
| Special information that the youth or family wants health care professionals to know | | | |
| | | | |
| <hr/> | | | |
| Youth signature | Print Name | Phone Number | Date |
| <hr/> | | | |
| Parent/Caregiver | Print Name | Phone Number | Date |
| <hr/> | | | |
| Primary Care Provider Signature | Print Name | Phone Number | Date |
| <hr/> | | | |
| Care Coordinator Signature | Print Name | Phone Number | Date |

Please attach the immunization record to this form.