Swindells Resource Center of Providence Child Center
Providing support for families of children with special needs

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Portland OR 97213
503.215.2429

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503.215.2429

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9135 SW Barnes Road Suite 561
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Swindells@providence.org
833-868-4769
Swindells Resource Center

This Care Notebook is free to all families of children who experience disability or special needs in Oregon or Southwest Washington. It is intended to help families organize the many pieces of their child’s life in the simplest manner possible. Whether your child has a medical, developmental or mental health diagnosis, you are in charge of the information you need to have with you when at appointments.

The Swindells Center staff searched national, regional, and local resources for the best information and with the careful guidance of parents and providers, developed these pages to make it easier to share information with educators, therapists and family. We appreciate the parents, grandparents, family members and foster parents who shared their perspectives, knowledge, and experiences during this project.

Care notebook trainings:
We welcome the opportunity to help you tackle all that paperwork. Please call to make an appointment for our next training. Bring in those boxes and bags of information and paperwork and we are happy to help you organize it.

How do I get a notebook?
Families may receive one Care Notebook per child with special needs at no cost. Families should call or email the Swindells Center to make their request.

The Swindells Center:
503.215.2429
833.868.4769
Swindells@providence.org
The Care Notebook can make life a little easier!

Set up the notebook:

This notebook was developed to help families of children who experience disability or special health care needs track the many important pieces of information regarding their care and day-to-day needs.

As you care for your child, you get paperwork, forms, letters and other items that you may not know where to keep or how to use. The notebook can help you keep and share information with your family members, as well as your child’s education and healthcare team.

Use your notebook to:

- Share your child’s routine, preferences, and needs with your family members, child care providers and friends.
- Retain your child’s health history and records.
- Track changes in your child’s medicines or treatments.
- Keep evaluations and appointment schedules in one easy spot.
- Have your family medical history ready.
- List phone numbers of health care providers and other community support agencies

Consider these helpful hints when using the notebook:

Keep this notebook where it is easy to find, taking it with you to all doctor, therapy and school appointments.

Add new information whenever there is a change in your child’s daily routine, schedule or treatment. Medical offices can copy evaluation reports, immunization records, and specialist reports and give them to you to insert into the notebook.

Gather the paperwork and information you have about your child. This could include prescription slips, medical records, summary of hospital stays, child’s school reports, dietary needs and medication.

Look through the notebook:

Which of these pages could help you keep track of information about your child’s health or care?

Chose the pages you like. Make this Notebook work for you! Contact us for replacement pages!

Decide which information is most important to keep in the notebook:

What information do you look up often?

What information might those who care for your child need?

Put your notebook together.

- Personalize the cover by using your child’s photo or artwork. Make it your own!
- Everyone has different ways of organizing information. The only important thing is that you make it easy...
for YOU to locate the information you need.

- Tabbed dividers: Create your own sections.
- Pocket dividers: Store reports and loose materials.
- Plastic pages: Store business cards, insurance cards and photographs.
I appreciate it when you:

Remember that it is normal and healthy to feel anger and denial sometimes when I grieve my child’s extra challenges.

Realize that I am struggling to regain my balance in a confusing and challenging situation.

Recognize that my child’s health needs don’t erase the other real life challenges all families face: bills, job stressors, plumbing issues and not enough time in any day.

Listen when I say is something wrong. I know my child. Help me solve the puzzle until we both understand what is going on. Telling me my child will outgrow it only frustrates me and it could be harmful to my child.

Help me to be a competent partner in healthcare. I have to be. My child relies on me for everything.

Help me find the information I need to understand my child’s condition. Send me to resource centers or other providers if you need to. Tell me what books and articles are the good ones. The more I know about my child, the more I can enjoy and work with my child.

Realize you can’t tell me too much about my child’s condition. I may not absorb it all at once, so you may have to repeat yourself.

Help me enjoy the smallest successes and recognize my child’s limitations for what they are.

Keep me informed about everything, even referrals. Call me, send me a note, and let me know that my child has not been forgotten or lost in a tangle of procedural tape.

See my whole child, not just the diagnosis.

Work with the other professionals who are involved in my child’s care. We each hold only one piece of the puzzle.

I don’t think these are too much to ask for. Do you?

Created by: Swindells Family Advisory Board, 2007
HEALTH INFORMATION

This section provides information that you or another caregiver might need in providing medical care for your child. Information includes:

- Medical and health summary
- Emergency contact information
- Medical power of attorney
- Information regarding changes to treatment plan
- Personal and family medical history
- Insurance information
- Appointment log
- Information regarding medications, past and present
- Hospital and surgical care
- Lists of care providers and specialists
- List of specialized equipments and vendors
- Summaries of specific care needs
- Dental care information and log
- Behavioral health care information and log
IN CASE OF AN EMERGENCY:

Child’s Name:________________________  Nickname: ___________________________
Child’s Date of Birth:_______________  Child’s SSN:_________________________

Primary Language/Communication Means:_______________________________________

Parent/Guardian Names:_______________________________________________________
Relationship to Child:________________________________________________________

Home Address:________________________________________________________________
Emergency Contact Numbers:____________________________________________________
Name of School:____________________________  Phone:________________________

Personal Descriptors:
Gender:________________________________
Height:______________    Weight: _______________                                (Photo Here)
Hair Color: __________   Eye color:______________
Scars or birthmarks: __________________________
Glasses:         Yes      No      Hearing Aids: Yes     No
Primary Diagnosis:__________________________
Co-existing diagnosis: _________________________

Medications            Dose             Time:
1.________________________ _________________________ ____________________
2.________________________ _________________________ ____________________
3.________________________ _________________________ ____________________
4.________________________ _________________________ ____________________
Allergies:________________________________________________________________

Emergency Contacts
Name and relationship:_______________________________________________________
Address:___________________________________________________________________
Phone:_____________________Work : __________________Cell:__________________

Primary Care
Physician:________________________________________Phone:_________________
Specialist:________________________________________ Phone:_________________
Specialist:________________________________________ Phone:_________________

Additional Information to know about my child in an emergency (sensitivities, seizures, previous events – on reverse):
MEDICAL POWER OF ATTORNEY:

I, __________________________________________ do give permission

   (Name of Parent or Guardian)

for the following people to make decisions regarding medical treatment for my
child, ______________________________, should the need arise.

   (Child’s Name)

Power of Attorney is given for emergency medical and dental care, including
anesthesia when it is needed. This consent is effective from this date and
remains active until the date indicated here, unless otherwise revoked:

   ________________

   Date

Name: ________________________________
Address: ________________________________
Phone: ________________________________
Cell: ________________________________

Name: ________________________________
Address: ________________________________
Phone: ________________________________
Cell: ________________________________

Name: ________________________________
Address: ________________________________
Phone: ________________________________
Cell: ________________________________

NOTARY

Parent name: ________________________________
Parent signature: ________________________________
Date: ________________________________
Notary name: ________________________________
Notary signature: ________________________________
Date: ________________________________

Swindells Resource Center of Providence Child Center
MY CHILD’S INFORMATION AND HEALTH SUMMARY

PERSONAL INFORMATION:
Name:___________________________________ Nickname:___________________________________
Date of Birth:___________ Social Security Number:____________ Blood Type:_________
Primary Diagnosis:_______________________________________________________
________________________________________________________________________
Insurance Company: ___________________ ID#_______________ Group#________
Primary Language Spoken at home:___________________________________________
Other language familiar to child:______________ Interpreter Needed: □ Yes □ No

Parent(s)/Legal Guardian(s):________________________________________________
Address:_________________________________________________________________
Phone:__________________ Cell:________________ Email:_______________________

SPECIAL CARE NEEDS:
Allergies:_________________________________________________________________
Special Safety Instructions/Crisis Plan:_________________________________________
________________________________________________________________________
Challenges with movement, hearing, eyesight, thinking:____________________________
________________________________________________________________________
Special Equipment, treatment challenges, unusual findings:_________________________
________________________________________________________________________

FAMILY INFORMATION:
Siblings Name:___________ Age: _____ Name:___________ Age:____
Name:___________ Age: _____ Name:___________ Age:____
Other Household Members:_________________________________________________________________

Emergency Contact: Name:________________________ Relationship to Child:____________________
Address:___________________________________________________________________________
Phone:__________________ Cell:________________ Email:__________________________
KEEPING MY CHILD’S TEAM UP TO DATE

DATE:

To: ________________________________ From: ______________________________________

Re: _______________________________ Date of Birth: _____________________________

(child’s name)

This note is to keep you informed of a change in treatment for my child. The following action has been taken by: _______________________________________________.

(Professional’s name and title)

They provide the following service for my child:____________________________________

And can be reached at the following phone number and address:____________________

____________________________________

☐ Medication Change

  Dosage Change: from_______________ to_______________

  Type of Medication: from_____________ to____________________

☐ Change to Treatment Plan____________________________________________________

☐ Change to IEP_______________________________________________________________

Report, lab test result (copies) or other paperwork are attached and include:___________

____________________________________

Any other important changes in my child’s life:____________________________________

____________________________________

Please include this information in my child’s records. I can be reached at:_____________

at the following times:_________________. _____________________________________
SUMMARY OF CARE
MEDICAL HISTORY

Birth History Unknown ☐
Child’s Name: ___________________________ Date of Birth: __________________

Pregnancy/Birth History

Smoker: ☐ Yes ☐ No Amount: __________________
Alcohol use during pregnancy: ☐ Yes ☐ No Amount: __________________
Drug use during pregnancy: ☐ Yes ☐ No Type/Amount: __________________

Complications or illnesses during pregnancy or at birth (jaundice, prematurity)?
________________________________________________________________________

Child’s Weight at Birth _____lbs _____oz. APGAR Score_______ Length_______ inches

Child’s Blood Type________ Date of Last Physical Exam:____________

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<th>Immunizations:</th>
<th>Dates:</th>
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<td>DTaP</td>
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<td>Polio</td>
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<td>MMR</td>
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<td>HiB</td>
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<td>Varicella</td>
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<td>PPD/Mantoux</td>
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<td>HEP A</td>
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<td>HEP B</td>
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<td>Rotovirus</td>
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Does your child have a history of any of the following?

☐ Colds Additional Info/Date: ☐ Cleft Palate
☐ Respiratory Infections Additional Info/Date: ☐ Developmental Delay
☐ Influenza Additional Info/Date: ☐ Seizures
☐ Sinusitis Additional Info/Date: ☐ Hearing Impairments
☐ Ear Infections Additional Info/Date: ☐ Constipation/Diarrhea
☐ High Fever Additional Info/Date: ☐ Head Injury
☐ Vision Problems Additional Info/Date: ☐ Coma
☐ Tonsillitis Additional Info/Date: ☐ Metabolic Disorder
☐ Bronchitis Additional Info/Date: ☐ Failure to thrive
☐ Asthma Additional Info/Date: ☐ Anemia
☐ Chicken Pox Additional Info/Date: ☐ Pneumonia
☐ Heart Problems Additional Info/Date: ☐ Reflux
☐ Other: Additional Info/Date: ☐ Other:
<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
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<tr>
<td>Allergies</td>
<td>Please list:</td>
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<td>Fractures</td>
<td>Please specify:</td>
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<tr>
<td>Genetic Syndrome</td>
<td>Please specify:</td>
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<tr>
<td>Surgery</td>
<td>Please specify:</td>
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**SUMMARY OF CARE**  
**FAMILY HEALTH HISTORY**

*Family History Unknown* □

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<thead>
<tr>
<th>Problem</th>
<th>Relation (parent, sibling, grandparent, etc.)</th>
<th>Age when diagnosed</th>
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<tr>
<td>Alcohol/ Drug Abuse</td>
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<tr>
<td>Allergies</td>
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<td>Heart Conditions</td>
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<td>Down Syndrome</td>
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<td>Arthritis</td>
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<td>Vascular Disorders</td>
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<td>Feeding</td>
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<td>Stomach/Bowel</td>
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<td>Hearing Loss</td>
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<td>Intellectual Disability</td>
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<td>Developmental Delay</td>
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<td>Mental Illness</td>
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<td>Emotional/Behavioral</td>
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<td>Breathing Problems</td>
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<td>Asthma</td>
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<td>Seizures</td>
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<td>Speech &amp; Language</td>
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<td>Kidney and Bladder</td>
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<td>Eyes/Vision</td>
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<td>Diabetes</td>
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<td>Autism Spectrum</td>
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<tr>
<td>Genetic Disorder</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Other</td>
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Other comments or helpful information:
SUMMARY OF CARE

INSURANCE INFORMATION

Insurance Company:_______________________________________________________________
Policy/ID Number:_______________________ Group Number:_____________________
Contact Person/Title: _________________________________________________________
Address:_________________________________________________________________
Phone:___________________ Fax:__________________ Email:_____________________
Website:_________________________________________________________________

Insurance Company:_______________________________________________________________
Policy/ID Number:_______________________ Group Number:____________________
Contact Person/Title: _________________________________________________________
Address:_________________________________________________________________
Phone:___________________ Fax:__________________ Email:_____________________
Website:_________________________________________________________________

Insurance Company:_______________________________________________________________
Policy/ID Number:_______________________ Group Number:_____________________
Contact Person/Title: _________________________________________________________
Address:_________________________________________________________________
Phone:___________________ Fax:__________________ Email:_____________________
Website:_________________________________________________________________

Supplemental Security Income (SSI):
Contact Person/Title: _________________________________________________________
Address:_________________________________________________________________
Phone:___________________ Fax:__________________ Email:_____________________
Website:_________________________________________________________________

Other:
Contact Person/Title: _________________________________________________________
Address:_________________________________________________________________
Phone:___________________ Fax:__________________ Email:_____________________
Website:_________________________________________________________________
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<tr>
<th>Date</th>
<th>Height / Weight</th>
<th>Provider</th>
<th>Procedure / Reason for Visit</th>
<th>Results</th>
<th>Follow up</th>
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**SUMMARY OF CARE**  
**HOSPITAL AND FOLLOW UP CARE**

*Investigate your child’s Insurance coverage to see what, if any, on-going therapy or hospital care is covered, and make sure you are getting the most from your provider.*

Hospital Name: _____________________________________________________________
Address: ___________________________________________________________________
City, State, Zip_______________________Website: _______________________________
Switchboard Number: ____________________ Emergency Room Extension:_________

<table>
<thead>
<tr>
<th>Medical Record #</th>
<th>Physician:</th>
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Additional Contact Person:

Summary of Treatment Provided:

Phone: ___________________ Fax: __________ Email: __________

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<tr>
<th>Clinic Name and location</th>
<th>Medical Record #</th>
<th>Physician/Therapist(s):</th>
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Treatment Type:

Phone: ___________________ Fax: __________ Email: __________

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<tr>
<th>Clinic Name and location</th>
<th>Medical Record #</th>
<th>Physician/Therapist(s):</th>
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Treatment Type:

Phone: ___________________ Fax: __________ Email: __________
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<tr>
<th>Date</th>
<th>Hospital</th>
<th>Reason for Stay</th>
<th>Follow up</th>
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MEDICAL VISIT CHECK SHEET

Use this page to prepare for and track medical appointments.

My child’s name is: ______________________________ Today’s Date: ______________

Reason for today’s visit:

My biggest concerns are:

Weight: _________________________
Height:__________________________

Current Medications:

Doctor’s Notes / Today’s Diagnosis:

Medication and Instructions:

Follow up Plan:
## SUMMARY OF CARE

### MEDICATION INFORMATION

Pharmacy: ________________________________ Phone: ________________________________
Address: ________________________________ Fax: ________________________________

Allergies to Medications: __________________________________________________________

<table>
<thead>
<tr>
<th>Medication &amp; Prescription Number</th>
<th>Date Started</th>
<th>Date Stopped</th>
<th>Dosage</th>
<th>Directions: (how much, time given, delivery method, side effects, special instructions)</th>
<th>Prescribed by: (name/phone)</th>
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<td>Prescribed by: (name/phone)</td>
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Swindells Resource Center of Providence Child Center
SERVICE PROVIDERS
MEDICAL / DENTAL

Primary Care Provider:
(Date of First Visit:___________________ Medical Record #:________________________
Address:_________________________________________________________________
Phone:____________________Fax:_________________Email:_____________________
Website:_________________________________________________________________

Developmental Pediatrician:
(Date of First Visit:___________________ Medical Record #:________________________
Address:_________________________________________________________________
Phone:____________________Fax:_________________Email:_____________________
Website:_________________________________________________________________

Preferred Hospital:
(Date of First Visit:___________________ Medical Record #:________________________
Address:_________________________________________________________________
Phone:____________________Fax:_________________Email:_____________________
Website:_________________________________________________________________

Dentist:
(Date of First Visit:___________________ Medical Record #:________________________
Address:_________________________________________________________________
Phone:____________________Fax:_________________Email:_____________________
Website:_________________________________________________________________

Orthodonist:
(Date of First Visit:___________________ Medical Record #:________________________
Address:_________________________________________________________________
Phone:____________________Fax:_________________Email:_____________________
Website:_________________________________________________________________

Specialty Care Provider:
(Date of First Visit:___________________ Medical Record #:________________________
Address:_________________________________________________________________
Phone:____________________Fax:_________________Email:_____________________
Website:_________________________________________________________________
SERVICE PROVIDERS
THERAPISTS

Occupational Therapist (OT):
Date of First Visit:______________________ Medical Record #:_____________________
Address:_________________________________________________________________
Phone:____________________Fax:_________________Email:_____________________
Website:_________________________________________________________________

Speech-Language Therapist (SLP):
Date of First Visit:______________________ Medical Record #:_____________________
Address:_________________________________________________________________
Phone:____________________Fax:_________________Email:_____________________
Website:_________________________________________________________________

Physical Therapist (PT):
Date of First Visit:______________________ Medical Record #:_____________________
Address:_________________________________________________________________
Phone:____________________Fax:_________________Email:_____________________
Website:_________________________________________________________________

Mental Health Therapist:
Date of First Visit:______________________ Medical Record #:_____________________
Address:_________________________________________________________________
Phone:____________________Fax:_________________Email:_____________________
Website:_________________________________________________________________

Audiologist:
Date of First Visit:______________________ Medical Record #:_____________________
Address:_________________________________________________________________
Phone:____________________Fax:_________________Email:_____________________
Website:_________________________________________________________________

Specialty Care Provider:
Website:_________________________________________________________________
**SERVICE PROVIDERS**

**EQUIPMENT / SUPPLIES**

**Name of Equipment:**

Description: (brand, model number, size)

Date obtained: ________________  Supplier: ____________________________

Contact Person: ____________________________

Phone: ________________ Fax: ________________ Email: ____________________________

Website: ________________________________________________________________

**Name of Equipment:**

Description: (brand, model number, size)

Date obtained: ________________  Supplier: ____________________________

Contact Person: ____________________________

Phone: ________________ Fax: ________________ Email: ____________________________

Website: ________________________________________________________________

**Name of Equipment:**

Description: (brand, model number, size)

Date obtained: ________________  Supplier: ____________________________

Contact Person: ____________________________

Phone: ________________ Fax: ________________ Email: ____________________________

Website: ________________________________________________________________

**Name of Equipment:**

Description: (brand, model number, size)

Date obtained: ________________  Supplier: ____________________________

Contact Person: ____________________________

Phone: ________________ Fax: ________________ Email: ____________________________

Website: ________________________________________________________________

Swindells Resource Center of Providence Child Center
SUMMARY OF CARE
SKIN CONDITIONS

Use this page to track any of your child’s special skin or hair care needs, including sensitivity or allergies to scents.

What is the overall condition of your child’s skin?:

☐ good  ☐ dry  ☐ rashes  ☐ bruises  ☐ bed sores  ☐ wounds

How do you treat any skin problems?

What hair care product(s) do you use for your child?:

•

•

•

What skin care product(s) do you use for your child?:

•

•

•

What other helpful skin care items do you use for your child?:

•

•

•

Other comments or helpful information:
SUMMARY OF CARE

SEIZURE CONDITIONS

☐ Does not apply to my child

If your child has experienced seizures, please describe:
(duration, type of body movement, color changes that occur, recognized triggers)

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

How often does your child have seizures?: ☐ more than 1x a day  ☐ weekly  ☐ monthly

How do you treat seizures that last longer than 5 minutes?:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Does your child have a vagal nerve stimulator?  ☐ yes  ☐ no
Does your child have a VP shunt?  ☐ yes  ☐ no
If yes, what was the date of its last revision?  ___________________________

Is your child currently, or have they ever, been on the ketogenic diet?  ☐ yes  ☐ no

Which diagnostic studies has your child received? (Please list date and result):

☐ CT scan:______________________________________________________
☐ MRI: _________________________________________________________
☐ EEG:_________________________________________________________

Please list all seizure medications your child is currently taking:
•
•

Which seizure medications has your child tried in the past, but is not currently taking?

☐ Depakote  ☐ Depakene  ☐ Dilantin  ☐ Felbatol
☐ Gabitril  ☐ Lamictal  ☐ Phenobarbital  ☐ Tegretol
☐ Topiramate  ☐ other ______________________
SUMMARY OF CARE
SENSORY AND COMMUNICATION

Vision:
Clinic: ____________________________  Ophthalmologist/  Optometrist: ____________________________
Date of first visit: _________________  Medical record #: ____________________________
Address: ____________________________________________________________
Phone: __________________ Fax: ____________ Email: ____________________________
Website: ___________________________________________________________________
Last date of vision exam: ___________________________________________________________________

Results, if known:
☐ Glasses  ☐ Contact lens  ☐ Prosthesis  ☐ Other ____________
☐ Surgery/Lasik  ☐ History of ROP (retinopathy or prematurity)

Other comments or helpful information:

Audiology/Hearing:
Clinic: ____________________________  Audiologist: ____________________________
Date of first visit: _________________  Medical record #: ____________________________
Address: ____________________________________________________________
Phone: __________________ Fax: ____________ Email: ____________________________
Website: ___________________________________________________________________
Last date of hearing exam: ___________________________________________________________________

Additional tests: _____________________________________________________________
Results: ______________________________________________________________________
Additional Tests: ___________________________________________________________________
Results: ______________________________________________________________________
☐ Wears aids  ☐ Right ear  ☐ Left ear  ☐ Both ears

Other comments or helpful information:
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 (English)  ☐ Other ________________________________

Other comments or helpful information:
SUMMARY OF CARE
BREATHING/RESPIRATORY

☐ Does not apply to my child

Does your child have history of breathing problems? ☐ yes ☐ no

Use this page to detail your child’s respiratory history and care needs.

☐ asthma ☐ pneumonia ☐ cystic fibrosis ☐ tuberculosis

☐ apnea (not breathing) ☐ other __________

Additional information:

Does your child have a tracheostomy? ☐ Yes ☐ No

Brand and size __________________________________________

Does your child require oxygen treatments? ☐ Yes ☐ No

If yes, how often?
☐ never ☐ intermittently ☐ continuously

Check if your child uses:

☐ Ventilator: type __________ ☐ CPAP machine ☐ monitor ☐ pulse oximeter

Setting information:________________________________________________________________

What kind of breathing treatments or medications does your child require?

☐ Albuterol nebulizer? Or puffs? ☐ suctioning ☐ clapping (CPT)

☐ Intal nebulizer? Or puffs? ☐ mist ☐ oxygen

☐ Liters ☐ Provental nebulizer? Or puffs?

Other comments or helpful information:

Swindells Resource Center of Providence Child Center
SUMMARY OF CARE
PAIN MANAGEMENT

☐ Does not apply to my child

Does your child have pain concerns?

☐ always (daily)  ☐ often (less than daily)  ☐ not at all

What would best describe your child’s usual pain level?

☐ mild  ☐ moderate  ☐ severe

How does your child indicate they are in pain?:

Do you use medications or treatments to alleviate your child’s pain?:  ☐ Yes  ☐ No

If yes, please list:

If yes, at what point do you administer this treatment?

Other comments or helpful information:
SUMMARY OF CARE
HEART/CARDIAC

☐ Does not apply to my child

Name of heart condition:

Has your child had surgery for a heart problem? ☐ yes ☐ no

Date of surgery

Date of surgery

Date of surgery

Did the surgery correct the problem? ☐ yes ☐ no

Does your child have a pacemaker? ☐ yes ☐ no

Does your child have/take any medications regularly for the heart? ☐ yes ☐ no

If yes, please describe:

Other comments or helpful information:

Swindells Resource Center of Providence Child Center
SUMMARY OF CARE
MUSCLE / BONE ISSUES

☐ Does not apply to my child

Does your child currently have, or has he/she ever had:

☐ spasticity (tight) ☐ “floppy” ☐ contractures ☐ scoliosis ☐ broken bones:

☐ club foot ☐ tethered cord

Explain: _________________________________________________________________

Has your child had orthopedic (bone) surgery? ☐ yes ☐ no

If yes, please explain: ____________________________________________________
________________________________________________________________________
________________________________________________________________________

Does your child have a baclofen pump? ☐ yes ☐ no

Other comments or helpful information:
SUMMARY OF CARE
DENTAL CARE

Dental clinic: _____________________________________________________________

Dentist: __________________________ Date of first visit: _______________________

Address: __________________________________________________________________

____________________________________________________________________________

Phone:___________________ Fax:_________________ Email:_________________________

To prevent dental problems, all children should have routine dental care beginning when
the first tooth appears or before their first birthday (American Academy of Pediatric
Dentistry). Such care may be even more important if the child has special health needs.
Before the child is examined, the dentist should have knowledge of the child’s current
medical condition(s) and treatment(s). It is essential that the dentist have a
comprehensive, current list of all medications taken by the child.

☐ Dentist has been made aware of child’s medical conditions and recommendations of
medical specialists.

Has child had any problems or bad reactions to any previous dental treatment, surgery or
anesthesia? ☐ Yes ☐ No
If yes, explain:______________________________________________________________

Has child had any anxiety, sensory challenges, or adverse emotional responses at any previous
dental appointment? ☐ Yes ☐ No
If yes, explain how we can help your child cope:___________________________________

____________________________________

Has child experienced any abnormal bleeding (excessive bleeding or bruising) during any
previous treatment? ☐ Yes ☐ No
If yes, explain:______________________________________________________________

____________________________________

Other comments or helpful information:

____________________________________

Swindells Resource Center of Providence Child Center
# SUMMARY OF CARE
## DENTAL RECORD

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure/ Reason for Visit</th>
<th>Results</th>
<th>Follow up</th>
</tr>
</thead>
<tbody>
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SUMMARY OF CARE
BEHAVIORAL HEALTH
COPING & STRESS TOLERANCE

Child’s IQ measurement:____________________  Adaptive Age:____________________
Date of IQ Evaluation:______________________  Date of Age Evaluation:__________
☐ Child’s IQ has not been evaluated  ☐ Adaptive Age has not been evaluated

Sensory Modulation:
Does your child react too much or not enough to sensory stimulus (sounds, touch, light, scents)?
If yes, please explain___________________________________________________________
____________________________________________________________________________

Interpersonal Skills:
Does your child best respond to adults who are fast-paced? Patient and Calm? Structured or Unstructured? How does she/he get along in groups of children?______________________________
____________________________________________________________________________

Social Skills:
Is your child out-going or reserved? How does your child cope in social situations? Is she/he able to read social cues?________________________________________________________
____________________________________________________________________________

Emotional Modulation:
Does your child experience “melt-downs”? What behaviors might they exhibit prior to a meltdown? Is he/she affected by noisy or hectic situations? Is your child easily frustrated? What scenarios could cause negative emotional responses? ________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
How does your child calm themselves? _____________________________________________

How can adults help calm your child?______________________________________________

How does your child cope with transition?___________________________________________

How does your child ask for help?_________________________________________________

What techniques, words, reward systems do you use to assist your child when they are frustrated, anxious, over-stimulated, etc?_______________________________________
________________________________________________________________________
________________________________________________________________________

Describe situations or scenarios that would be difficult for your child and how you would comfort them?
FAMILY AND DAILY ROUTINES

This section provides information that you or another caregiver might need in providing daily care for your child. Information includes:

- Child’s personal statement
- Family’s Circle of Support
- Lists of Services Providers
- Information about:
  - Diet
  - Toileting
  - Milestones
  - Routine
  - Sleep Needs and Patterns
  - Communication
  - Mobility
  - Social Play
  - In home Care
  - Transportation
GET TO KNOW ME!

My Name:_________________________ My Nickname:____________________
My Birthday:______________________ Today’s Date:________________

Who am I? Here is how I describe myself:

My strengths and interests are:

My challenges are:

My community: (school, childcare, favorite places to go, eat, visit)

My Family and Home: (who lives in my house? Brothers or sisters? Grandparents?)

My diagnosis is:
**OUR FAMILY’S CIRCLE OF SUPPORT**

*Use this page to help you think about people, groups, agencies and programs that can offer practical, logistical or emotional support to your family and your child. This list will grow and evolve as you expand your circle.*

<table>
<thead>
<tr>
<th>People and Organizations:</th>
<th>Email/Phone</th>
<th>Support they provide</th>
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<tbody>
<tr>
<td>Family Members:</td>
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<td>Paid, Volunteer or Cooperative Respite Care:</td>
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<td>Community Programs or Support Groups:</td>
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Swindells Resource Center of Providence Child Center
### Parent to Parent program:

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<tr>
<th>Contact person:</th>
<th>Address:</th>
<th>Phone:</th>
<th>Fax:</th>
<th>Email:</th>
<th>Website:</th>
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### Parent group or class:

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<th>Contact person:</th>
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<th>Fax:</th>
<th>Email:</th>
<th>Website:</th>
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</table>

### Faith-based or religious organization:

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<tr>
<th>Contact person:</th>
<th>Address:</th>
<th>Phone:</th>
<th>Fax:</th>
<th>Email:</th>
<th>Website:</th>
</tr>
</thead>
</table>

### Behavior health or counseling services:

<table>
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<tr>
<th>Contact person:</th>
<th>Address:</th>
<th>Phone:</th>
<th>Fax:</th>
<th>Email:</th>
<th>Website:</th>
</tr>
</thead>
</table>
SUMMARY OF CARE
DIET AND NUTRITION

My child is/was breast fed. □ yes □ no

If your child is currently breast feeding, how often?

□ every 1.5 hours □ every 2-3 hours □ every 4 hours □

If your child is currently being fed formula, please list brand: ________________________

How often is your child fed each day?

□ every 1.5 hours □ every 2-3 hours □ every 4 hours □ __________

Does your child require any nutritional supplements? □ yes □ no

If yes, please list:__________________________________________________________

Please list any known allergies or restrictions to food:

Please list any special techniques, precautions or equipment used during feeding:

Does your family have any special routines that help during feeding? Please list:

Other comments or helpful information:
SUMMARY OF CARE

TOILETING

- Is your child potty-trained
  If yes, age of child? ____________
  □ yes □ no

- How often does your child have a bowel movement?
  □ daily □ every 2-3 days □ 4 days or longer

Special toileting needs:
□ Does not apply to my child

- Does your child have bladder control?
  □ yes □ no

- Does your child have a history of urinary tract infections?
  □ yes □ no

- Does your child have bowel control?
  □ yes □ no

- Does your child have history of constipation / impaction?
  □ yes □ no

- Does your child suffer from diarrhea?
  □ yes □ no

- Does your child use laxatives?
  □ yes □ no
  (Check all that apply)
  □ colace □ lactulose □ milk of magnesia
  □ mineral oil □ senna □ miralax □ other ____________

- Does your child use suppositories or enemas?
  □ yes □ no
  □ bisacodyl (dulcolax) □ saline enema □ phosphate enema
  □ glycerin adult? Pediatric? Or infant? (Fleets) □ other ____________

Does your child have a toileting program?
□ yes □ no

If yes, please describe: __________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Other comments or helpful information:
<table>
<thead>
<tr>
<th><strong>DATE/AGE</strong></th>
<th><strong>NOTES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifted head while on tummy</td>
<td></td>
</tr>
<tr>
<td>Rolled over –tummy to back</td>
<td></td>
</tr>
<tr>
<td>Sat with support</td>
<td></td>
</tr>
<tr>
<td>Rolled over- back to tummy</td>
<td></td>
</tr>
<tr>
<td>Sat without support</td>
<td></td>
</tr>
<tr>
<td>Pulled to stand with support</td>
<td></td>
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<tr>
<td>Started cruising</td>
<td></td>
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<tr>
<td>Stood without support</td>
<td></td>
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<tr>
<td>First steps without support</td>
<td></td>
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<tr>
<td>Walked</td>
<td></td>
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<tr>
<td>Started solid foods</td>
<td></td>
</tr>
<tr>
<td>Started babbling</td>
<td></td>
</tr>
<tr>
<td>First words</td>
<td></td>
</tr>
<tr>
<td>First started to speak in sentences</td>
<td></td>
</tr>
</tbody>
</table>
**MY CHILD’S DAILY ROUTINE**

*Use this page to communicate your child’s routine with caregivers*

<table>
<thead>
<tr>
<th>Morning routine</th>
</tr>
</thead>
<tbody>
<tr>
<td>My child is ready to get out of bed when…..</td>
</tr>
<tr>
<td>First thing in the morning, my child will…</td>
</tr>
<tr>
<td>Favorite clothing</td>
</tr>
<tr>
<td>Where shoes are usually hiding</td>
</tr>
<tr>
<td>Routines that make dressing easier</td>
</tr>
<tr>
<td>Toys that make mornings better</td>
</tr>
<tr>
<td>For breakfast my child usually eats…</td>
</tr>
<tr>
<td>Foods to avoid</td>
</tr>
<tr>
<td>Usual length of time to eat</td>
</tr>
<tr>
<td>Signs my child is full</td>
</tr>
<tr>
<td>Ways to encourage better eating</td>
</tr>
<tr>
<td>Use this page to communicate your child’s routine with caregivers</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Some areas are off-limits to my child in the house</td>
</tr>
<tr>
<td>How to calm or soothe my child</td>
</tr>
<tr>
<td><strong>Daytime routine</strong></td>
</tr>
<tr>
<td>We take a walk to:</td>
</tr>
<tr>
<td>Favorites songs to listen to</td>
</tr>
<tr>
<td>Favorite shows to watch</td>
</tr>
<tr>
<td>Favorite books to read</td>
</tr>
<tr>
<td>Signs my child is needing a nap or quiet time</td>
</tr>
<tr>
<td>Nap times (hints for success)</td>
</tr>
<tr>
<td>Snack times (hints for success)</td>
</tr>
<tr>
<td>For Lunch, my child likes to eat…</td>
</tr>
<tr>
<td>Foods to avoid</td>
</tr>
<tr>
<td>Usual length of time to eat</td>
</tr>
<tr>
<td>Signs my child is full</td>
</tr>
<tr>
<td>Evening routine</td>
</tr>
<tr>
<td>-------------------------------</td>
</tr>
<tr>
<td>For dinner, my child likes to eat</td>
</tr>
<tr>
<td>Foods to avoid</td>
</tr>
<tr>
<td>Usual length of time to eat</td>
</tr>
<tr>
<td>Signs my child is full</td>
</tr>
<tr>
<td>Ways to encourage better eating</td>
</tr>
<tr>
<td>Signs my child is ready for sleep</td>
</tr>
<tr>
<td>Bedtime ritual and toys</td>
</tr>
<tr>
<td>What to avoid in the bedroom</td>
</tr>
<tr>
<td>What my child wears to sleep</td>
</tr>
<tr>
<td>What helps my child fall asleep</td>
</tr>
<tr>
<td>What cues help keep my child in bed</td>
</tr>
<tr>
<td>Best methods for giving medication are</td>
</tr>
<tr>
<td>Where the medications are kept</td>
</tr>
</tbody>
</table>

Swindells Resource Center of Providence Child Center
## Use this page to communicate your child’s routine with caregivers

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>TV rules</td>
<td></td>
</tr>
<tr>
<td>Radio rules</td>
<td></td>
</tr>
<tr>
<td>Music rules</td>
<td></td>
</tr>
<tr>
<td>Computer or video game rules</td>
<td></td>
</tr>
</tbody>
</table>

Other comments or information:
# MY CHILD’S REST AND SLEEP PATTERNS

*Use this page to describe your child’s sleep habits and routines. Mention any items they need for comfort or reassurance.*

<table>
<thead>
<tr>
<th>How my child sleeps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tools/equipment that help with sleep</td>
</tr>
<tr>
<td>Routines and rituals that help with sleep</td>
</tr>
<tr>
<td>Security/comfort objects that help with sleep</td>
</tr>
<tr>
<td>Positioning information and routines</td>
</tr>
<tr>
<td>Medication information and schedule</td>
</tr>
</tbody>
</table>

**Other comments or helpful information:**
**MY CHILD’S COMMUNICATION**

*Use this page to share your child’s communication skills, tools and ability. Include sign language, equipment, picture symbols, etc. that your child uses to communicate.*

<table>
<thead>
<tr>
<th>How my child communicates</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tools that help my child communicate</td>
<td></td>
</tr>
<tr>
<td>Gestures/images my child uses to show fear</td>
<td></td>
</tr>
<tr>
<td>Gestures/images my child uses to show hunger</td>
<td></td>
</tr>
<tr>
<td>Gestures/images my child uses to show toileting needs</td>
<td></td>
</tr>
<tr>
<td>Gestures/images my child uses to show:</td>
<td></td>
</tr>
<tr>
<td>Gestures/images my child uses to show:</td>
<td></td>
</tr>
<tr>
<td>Gestures/images my child uses to show:</td>
<td></td>
</tr>
</tbody>
</table>

| Other comments or helpful information: |  |
## MY CHILD’S MOBILITY

*Use this page to share information about your child’s ability to get about. Include information regarding assistance they may require, equipment they use, or information regarding transfers, positioning, etc.*

<table>
<thead>
<tr>
<th>How my child moves about</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tools/equipment that aid in movement</td>
<td></td>
</tr>
<tr>
<td>Actions my child can take without assistance</td>
<td></td>
</tr>
<tr>
<td>Motor activities my child needs assistance with</td>
<td></td>
</tr>
<tr>
<td>Positioning information and routines</td>
<td></td>
</tr>
<tr>
<td>Transfer information and routines</td>
<td></td>
</tr>
</tbody>
</table>

Other comments or helpful information:
**MY CHILD’S SOCIAL/ PLAY INFORMATION**

Use this page to describe your child’s interactions and how they get along with others. Are there routines or language that encourages your child to play and cooperate with others? Do you have tools that help them make transition to other activities?

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>How my child indicates affection</td>
<td></td>
</tr>
<tr>
<td>How my child indicates fear</td>
<td></td>
</tr>
<tr>
<td>How my child plays with other children</td>
<td></td>
</tr>
<tr>
<td>My child’s favorite activity with others</td>
<td></td>
</tr>
<tr>
<td>What encourages my child to cooperate</td>
<td></td>
</tr>
<tr>
<td>What helps my child transition from one task to another</td>
<td></td>
</tr>
</tbody>
</table>

Other comments or helpful information:
Use this form to track in-home nursing, respite, or child care options.

| Provider:__________________________ | Contact:__________________________ |
| Agency:__________________________ | Availability:__________________________ |
| Address:____________________________________________________________________ |
| Phone:__________________________ | Fax:__________________________ | Email:__________________________ |
| Website:____________________________________________________________________ |

| Provider:__________________________ | Contact:__________________________ |
| Agency:__________________________ | Availability:__________________________ |
| Address:____________________________________________________________________ |
| Phone:__________________________ | Fax:__________________________ | Email:__________________________ |
| Website:____________________________________________________________________ |

| Provider:__________________________ | Contact:__________________________ |
| Agency:__________________________ | Availability:__________________________ |
| Address:____________________________________________________________________ |
| Phone:__________________________ | Fax:__________________________ | Email:__________________________ |
| Website:____________________________________________________________________ |

Preferred alternate staff:__________________________
| Agency:__________________________ | Availability:__________________________ |
| Address:____________________________________________________________________ |
| Phone:__________________________ | Fax:__________________________ | Email:__________________________ |
| Website:____________________________________________________________________ |

Other options:

Swindells Resource Center of Providence Child Center
Service Provider
Transportation

☐ Does not apply to my child

School transportation (company name):

Contact person: ___________________________  Fax: ___________________________
Phone: ___________________________  Fax: ___________________________
Website: ___________________________
Tips for successful scheduling: ___________________________

Days using school transport:
<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>am/pm</td>
<td>am/pm</td>
<td>am/pm</td>
<td>am/pm</td>
<td>am/pm</td>
</tr>
</tbody>
</table>

Medical appointment transport (company name):

Contact person: ___________________________  Fax: ___________________________
Phone: ___________________________  Fax: ___________________________
Website: ___________________________
Tips for successful scheduling: ___________________________

Days using school transport:
<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>am/pm</td>
<td>am/pm</td>
<td>am/pm</td>
<td>am/pm</td>
<td>am/pm</td>
</tr>
</tbody>
</table>

Additional transportation needs (company name):

Contact person: ___________________________  Fax: ___________________________
Phone: ___________________________  Fax: ___________________________
Website: ___________________________
Tips for successful scheduling: ___________________________
SCHOOL INFORMATION

This section identifies a location to keep and track the paperwork, evaluations, and plans generated in the school environment.

Suggested Information to Include:

- Copies of Individual Family Service Plan (IFSP’s)
- Copies of Individualized Education Plans (IEP’s)
- Report cards
- School evaluations
- School communication log
- Transition plans
- Post-secondary Information and plans
- School based behavior plans
SERVICE PROVIDERS
EARLY INTERVENTION

County Educational School District:____________________________________________
Start date:__________________________ End date:__________________________
Contact:____________________________ Contact:___________________________
Address:_________________________________________________________________
Phone:_____________________Fax:_________________Email:____________________
Website:_________________________________________________________________

Family resource coordinator:_____________________________________________________

Additional contact:____________________________________________________________
Start date:__________________________ End date:_______________________________
Contact:_____________________________ Contact:________________________________
Address:___________________________________________________________________
Phone:_____________________Fax:_________________Email:_______________________
Website:___________________________________________________________________

Teacher/therapist:_________________________________________________________
Start date:_____________________________ End date:____________________________
Address:_________________________________________________________________
Phone:_____________________Fax:__________________Email:__________________

Teacher/therapist:_________________________________________________________
Start date:____________________________ End date:___________________________
Address:_________________________________________________________________
Phone:_____________________Fax:__________________Email:__________________
SERVICE PROVIDERS
SCHOOLS

Preschool:_______________________________________________________________
Director:_____________________________ Teacher/s:__________________________
Address:_________________________________________________________________
Phone:_____________________Fax:___________________Email:__________________
Website:_________________________________________________________________

Days attending:
Monday Tuesday Wednesday Thursday Friday
am/pm  am/pm  am/pm  am/pm  am/pm

School:_____________________________________________________________________
Principal:_____________________________ Teacher/s:_____________________________
Special education staff:________________________________________________________
School secretary:__________________________ School nurse________________________
School guidance counselor:____________________________________________________
Address:____________________________________________________________________
Phone:_____________________Fax:___________________Email:____________________
Website:___________________________________________________________________

Before or After-School Program:

Director:_____________________________ Contact:_______________________________
Address:____________________________________________________________________
Phone:_____________________Fax:___________________Email:_____________________
Website:____________________________________________________________________

Days attending:
Monday Tuesday Wednesday Thursday Friday
am/pm  am/pm  am/pm  am/pm  am/pm

School transportation (company name):

Contact person:_________________________Phone:______________________________
Tips for successful scheduling:__________________________________________________

Days using school transport:
Monday Tuesday Wednesday Thursday Friday
am/pm  am/pm  am/pm  am/pm  am/pm

Swindells Resource Center of Providence Child Center
### SUMMARY OF CARE

#### TRANSITION TO ADULTHOOD

Use this page from time to time to track the preparation for transition to adulthood and the responsibilities and opportunities that accompany it. While this list is far from comprehensive, we hope that it encourages dialogue and gathering of resources.

Date: _______________  
Age: _______________

<table>
<thead>
<tr>
<th>Self Care:</th>
<th>Yes</th>
<th>No</th>
<th>Part Way There</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can take care of my personal grooming. (hair, bathing, teeth, dress)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I eat regular healthy foods and snacks.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I prepare my own meals and snacks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I avoid risky behaviors (including drugs and alcohol use)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am active and exercise regularly.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have a plan for what to do in case of natural disaster.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have a good friends and am active in my community.</td>
<td></td>
<td></td>
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<tr>
<td>I have established a transportation plan and can use it as needed.</td>
<td></td>
<td></td>
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<tr>
<td>I can safely manage my money or have a trusted person helping me do this.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>I understand and can recognize inappropriate contact by another person and know how to report it.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have received information about puberty and my developing body and feelings.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Care:</th>
<th>Yes</th>
<th>No</th>
<th>Part Way There</th>
</tr>
</thead>
<tbody>
<tr>
<td>I carry emergency health information and an Insurance card at all times.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have found a doctor who will take care of me when I turn 18.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can schedule and get to my appointments.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have a list of my current medications and allergies to medications.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know when and how to take my medications.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can communicate my questions to my doctor.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know my own health care needs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have a record of my immunizations.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• I know how to get help with my insurance.
• I have a list of all my specialist doctors.
• I have access to health insurance when I become an adult.

My Condition or Disability:
• I know how to find information about my condition/disability on the internet or at the library.
• I can describe my condition/disability to my family and friends.
• I know what accommodations I need to be successful at school or work and can explain them.
• I can explain my disability to a new or unfamiliar doctor.
• I know resources specific to my condition/disability in my community.

Community/Governmental Resources
• My family and I know about Supplemental Security Income/Social Security.
• My family and I have discussed guardianship.
• I have acquired photo Identification (State ID).
• I have my Social Security card.

Education:
• I have participated in my IEP meetings and understand my transition goals and timeline.
• I have made decisions about my plans after high school.
• I know about the Division of Vocational Rehabilitation and how it can help me.
SCHOOL COMMUNICATION RECORD
You can use this document to record episodes, communication and follow up incidents that occur while your child is at school.

<table>
<thead>
<tr>
<th>Date</th>
<th>Description of Incident</th>
<th>Communicated by:</th>
<th>Follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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