



**COUNTY OF ORANGE, CA HEALTH CARE AGENCY
EMERGENCY MEDICAL SERVICES AGENCY
EMERGENCY INFORMATION FOR CHILDREN WITH SPECIAL NEEDS**

Name _____ Date form completed _____ Initials _____

Home Address _____ Revised _____ Initials _____

_____ Revised _____ Initials _____

Emergency contacts Birth date _____

Name (relationship)/phone: Home phone _____

1. _____ 2. _____

Primary care physician Phone _____ Fax _____

Specialty physician Phone _____ Fax _____

Specialty physician Phone _____ Fax _____

Anticipated Primary ED _____

DNR form completed: _____ yes _____ no

Diagnoses

1. _____

2. _____

3. _____

4. _____

Synopsis

Allergies

1. _____

2. _____

3. _____

4. _____

Medications

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Significant baseline physical findings

Significant baseline ancillary findings (lab, radiography, ECG):

Management data

Medications to be avoided _____ **and why:** _____

1. _____

2. _____

3. _____

Procedures to be avoided _____ **and why:** _____

1. _____

2. _____

3. _____

Antibiotic prophylaxis

Indication _____

Medication and dose: _____

Common presenting problems/findings with specific suggested managements

Problem	Suggested Diagnostic Studies	Suggested Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

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