All About Me

Me and My Family

My Name _____

My Nickname_____

My Birthday_____

I live at ❑ Home ❑ School ❑ Foster Home ❑ Hospital ❑ Other

I live with ❑ Parent(s) ❑ Gaurdian(s) ❑ Sibling(s) ❑ Grandparent(s)

❑ Foster Parent(s) ❑ Family Friend(s) ❑ Other: _____

Family member names (first name/last name/relationship)

_____

_____

_____

_____

_____

Close friends, babysitters, neighbors (first name/last name/relationship)

_____

_____

_____

_____

Pets (Type/Name) _____

_____

_____

My Routine

I usually wake up at _____

I usually go to bed at _____

_____

Before bed, I usually _____

_____

I sleep in this type of bed _____

(single bed, enclosure bed, hospital bed, etc.)

with _____

(any needed equipment such as wedge, pulse ox, etc.)

Things I can do myself (brushing teeth, bathing, dressing, etc.)

_____

_____

_____

Things I need help with (brushing teeth, bathing, dressing, etc.)

_____

_____

_____

When I am happy you will know because I will _____

_____

When I am upset, you will know because I will _____

_____

I can be helped by _____

_____

All About Me (2)

My favorite things

Favorite Foods _____

Least Favorite Foods _____

Favorite Songs/Music _____

Favorite Toys/Games _____

Favorite Hobbies/Other Things _____

Favorite Books _____

Favorite Movies _____

Favorite TV Shows _____

Favorite Computer Games _____

Favorite Colors _____

Favorite Friends _____

Favorite People _____

In my free time I like to: _____

_____

_____

_____

Things I do not like: _____

_____

_____

_____

Other things I want you to know about me: _____

_____

_____

_____

Preferences

Communication

Can your child be understood by others? _____

Does your child read? _____

Preferred language/methods of communication:

❑ Talk ❑ Sign ❑ TTY ❑ Picture board ❑ Computer keyboard ❑ Gesture/facial

❑ Other _____

Are there specific words/gestures that have special meaning?

_____

_____

_____

_____

_____

_____

_____

Name of interpreter if required: _____

Is your child deaf/hearing impaired? _____

Is your child legally blind/visually impaired? _____

Child's Ethnicity

Family's preferred language: _____

Family's religious beliefs/customs that may affect treatment:

_____

_____

_____

_____

_____

_____

Notes

Personal Care and Hygiene

Independent

Things that I can do independently (i.e. brushing teeth)

Assistance

Things that I need assistance with

Other helpful information (i.e. shoe and clothing size, menstrual cycle, etc.)

Information for Caregivers

For babysitters, caregivers and respite care workers when you are away.

Parent/Guardian _____

Will be at _____ phone _____cell _____

Will be home at _____

Special instructions _____

_____

_____

_____

Significant events in the past 48 hours _____

_____

_____

_____

Medications

Name	Strength	Dosage	Time to be given

Call 911 in case of emergency.

Child's Name _____ Date of Birth _____

Home Phone _____

Address _____

_____

Primary Care Doctor/Phone _____

Other person to call in case of emergency _____

For EMT or ER personnel

Allergies _____

Baseline data _____

_____

Pulse rate _____ Site best taken _____

BP_____ Site best taken_____

Temp_____ Site best taken_____

Resp rate/minute_____ Oxygen saturation_____

Skin color_____ Best blood draw site_____

Pupils _____

Communication

Preferred method _____ Language _____

How child expresses pain _____

_____

These things can upset or overstimulate my child

(loud noises, bright lights, medical equipment, separation from parents/special item, touch, etc.)

_____

_____

These things can help calm my child

_____

_____

Primary Insurance

Company _____ Policy # _____

Policyholder Name _____ Group # _____

Secondary Insurance

Company _____ Policy # _____

Policyholder Name _____ Group # _____

In home

Extra equipment/supplies are located _____

Fuse box or breaker box is located _____

Fire extinguisher is located _____

Flashlights are located _____

Caregiver Task Sheet

Task	M	T	W	Th	F	Sa	Su

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Child's Name _____ **Date of Birth** / /

Date Last Revised: _____

Allergies

Food/Drug/Other	Reaction	What To Do (Give EpiPen®, Meds, Call 911, etc.)	Date Noted

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Child's Name _____ **Date of Birth** / /

Date Last Revised: _____

Baseline Data

Normal Vital Signs

Pulse rate _____ Site best taken _____

BP _____ Site best taken _____

Temp _____ Site best taken _____

Resp rate/minute _____

Oxygen saturation _____

Skin color _____

Best blood draw site _____

Pupils (normal, dilated, constricted, equal) _____

Systems	OK	Problem	Comments/Description
CNS/Sensory	❑	❑	
Heart/Blood (include recent blood counts)	❑	❑	
Gastrointestinal	❑	❑	
Respiratory (describe breath sounds)	❑	❑	
Gentourinary	❑	❑	
Muscoskeletal	❑	❑	
Baseline Xray findings	❑	❑	
Developmental	❑	❑	
Other:	❑	❑	
	❑	❑	
	❑	❑	
	❑	❑	
	❑	❑	
	❑	❑	
	❑	❑	

Normal Status

Areas to Check	Normal Status is	N/A
Activity level		
Behavior/attitude		
Body extremities lower		
Body extremities upper		
Blood sugars		
Communication		
Drainage		
Ears		
Eyes		
Feeding behaviors/Source		
Fontanels		
Motor skills		
Nose		
Ostomy sites		
Rash		
Seizure activity		
Sleeping patterns		
Stool		
Urine		
Vent dependent/trach/C-pap		
Verbal skills		
Other:		

Notes