

**The Snappy Finder
By
Snap4kids**

My Personal History

Name: _____

What I Liked to be Called: _____

My Caregivers: _____

Please call me: _____ or _____

Date of Birth: _____ Social Security #: _____ - _____ - _____

Where copy of birth certificate is located:

Where copy of Social Security card is located:

Home Address: _____

Phone#: _____ Fax#: _____

Emergency Contact: _____

Allergies: _____

Insurance Information

(Please note all insurance providers)

Company _____ ID# _____

Group # _____ Subscriber: _____

Case manager: _____ ph.# _____

Company _____ ID# _____

Group # _____ Subscriber: _____

Case manager: _____ ph.# _____

Company _____ ID# _____

Company _____ ID# _____

Group # _____ Subscriber: _____

Other: _____

Family Medical History

Family Health (Check where appropriate and note relationship to your child)

Cardiac	Hypertension	Renal
Tuberculosis	GI	Cancer
Allergy	Ortho	Lung
Diabetes	Blood	Ear
Thyroid	Vision	Neuro
Development	Psych	Auto Immune

Parents:

Father's Health _____

Mother's Health _____

Brothers and Sisters:

Name	Date Of Birth	Health

WHEN I WAS BORN:

(birth history, pregnancy, location, complications, neonatal hospitalization)

My Diagnosis

Date/Year	Diagnosis

Surgeries that I have had:

Date/Year	Surgery

Surgery Comments

My Primary Care Physician

My Immunization Record

DtaP	1.	2.	3.	4.	5.
DT	1.	2.			
Polio	1.	2.	3.	4.	
HIB	1.	2.	3.	4.	
Pevnar	1.	2.	3.	4.	
MMR	1.	2.			
Varicella	1.				
HBV	1.	2.	3.		
TB					
Flu					
Other					
Other					

Name: _____ Specialty _____

Phone#: _____ Fax# _____

Address: _____

All My Doctors

Name: _____ Specialty _____

Phone#: _____ Fax# _____

Address: _____

Name: _____ Specialty _____

Phone#: _____ Fax# _____

Address: _____

Name: _____ Specialty _____

Phone#: _____ Fax# _____

Address: _____

Name: _____ Specialty _____

Phone#: _____ Fax# _____

Address: _____

Name: _____ Specialty _____

Phone#: _____ Fax# _____

Address: _____

Name: _____ Specialty _____

Phone#: _____ Fax# _____

Address: _____

My nursing agency:

Name: _____ Phone: _____ Contact: _____

of hours approved: _____ Day: _____ Night: _____ Wknd: _____

Medication Information

My pharmacies:

(Include mail order pharmacies and prescription assistance programs)

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Medications:

Medication Name _____

Directions _____

Pharmacy Name & Phone _____

Prescribing Doctor & Phone _____

Medication Name _____

Directions _____

Pharmacy Name & Phone _____

Prescribing Doctor & Phone _____

Medication Name _____

Directions _____

Pharmacy Name & Phone _____

Prescribing Doctor & Phone _____

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Medication Name_____

Directions_____

Pharmacy Name & Phone_____

Prescribing Doctor & Phone_____

Medication Name_____

Directions_____

Pharmacy Name & Phone_____

Prescribing Doctor & Phone_____

Medical Equipment & Supplies

Medical Equipment Own/Use

Name of Equipment_____

Prescribed By_____

Reason Prescribed_____

Supplied By_____

Name of Equipment_____

Prescribed By_____

Reason Prescribed_____

Supplied By_____

Name of Equipment_____

Prescribed By_____

Reason Prescribed_____

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Reason Prescribed _____
Supplied By _____

Name of Equipment _____
Prescribed By _____
Reason Prescribed _____
Supplied By _____

Name of Equipment _____
Prescribed By _____
Reason Prescribed _____
Supplied By _____

Therapies

My Outpatient Therapies:

Therapy: _____ Frequency: _____

Therapist: _____ Phone#: _____

Location: _____

Therapy: _____ Frequency: _____

Therapist: _____ Phone#: _____

Location: _____

Therapy: _____ Frequency: _____

Therapist: _____ Phone#: _____

Location: _____

Therapy: _____ Frequency: _____

Therapist: _____ Phone#: _____

Location: _____

Therapy: _____ Frequency: _____

Therapist: _____ Phone#: _____

Location: _____

Therapy: _____ Frequency: _____

Therapist: _____ Phone#: _____

Location: _____

My School Therapies:

Therapy: _____ Frequency: _____

Therapist: _____ Phone#: _____

Therapy: _____ Frequency: _____

Therapist: _____ Phone#: _____

Therapy: _____ Frequency: _____

Therapist: _____ Phone#: _____

Additional Information on School Related Therapies: _____

My Daily Care

My Daily Medical Treatments

My Daily Treatments
(i.e. respiratory treatment, O₂, vent, trach, g-tube, etc.)
If you have a Plan of Care, please insert copy here

Vital Signs: (Freq.) _____

Adaptive Equipment: (W/C, braces, splints, speech devices) _____

Respiratory Tx (O₂, trach, vent, etc.) _____

Trach/G-tube/other care: _____

Bowel/Bladder Regime: _____

Other: _____

Other: _____

Nutrition Facts

Nutrition Notes:

Foods I like: _____

Favorite Restaurants and what your child enjoys eating there:

Foods I don't like: _____

Food Allergies:

Food _____ Reaction _____

Food _____ Reaction _____

Food _____ Reaction _____

Current diet: _____

Watch Me Grow

Date	Weight	Height	Head Circumference

Personal Care & Hygiene

Things that are done independently
(Example: brushes teeth)

Things that need assistance
(Example: bathes, but needs help regulating running water)

Other information that would be helpful
(Example: shoe and clothing size, menstrual cycle)

Behavior Management

What consistent approach has worked best in your absence during difficult transition periods? List typical interventions that have worked in certain situations. Provide name and description of techniques or things that are helpful and where they can be located. (Example: afraid of thunderstorms, use Walkman headphones to help block out the noise)

Things that help to calm me and when they should be used

Values

List your views about dating, sex, birth control and religion

Church Affiliation/Religious Preference _____

Sacraments/Program levels attained _____

More About Me

Activities I like to do

Things that can upset me/ things that I do not like to do

Any other important information

Education/Employment Opportunities

School History

Year	School	Teacher	School Nurse	Phone#

Education/Employment Opportunities:
Please attach copy of IEP or IHP or IFSP

I go to school at: _____ Phone#: _____

Teacher: _____ School Nurse: _____

School OT: _____ Phone #: _____ Frequency: _____

School PT: _____ Phone #: _____ Frequency: _____

School ST: _____ Phone #: _____ Frequency: _____

What is your child's work potential and employment history? What kinds of support does he/she receive and from which agencies?

Current Place of Employment _____

Contact Person _____

Address _____

Phone Number _____

Hours/Days worked _____

Previous Employment

What are your child's capabilities and skill levels? What other opportunities would like to see happen?

Social Experiences

Social Experiences

What activities make life meaningful for your son or daughter? What leisure activities does your child enjoy? List all hobbies, interests recreational and social activities and vacation preferences. Make a list of place and situation that your child is uncomfortable with or dislikes.

Favorite TV shows/movies

Hobbies/Activites in the home

Leisure Activities/Clubs outside the home

Name of Club _____
Contact Person _____
Phone Number _____
How Often _____

Name of Club _____
Contact Person _____
Phone Number _____
How Often _____

Special Interests

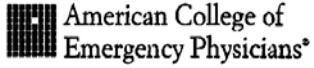
(Example: loves Cincinnati Reds Games in person but not on TV)

Favorite Vacations/Travels

Emergency Plan

Emergency Information Form for Children With Special Needs

Last name:



American Academy of Pediatrics



Date form completed	Revised	Initials
By Whom	Revised	Initials

Name:		Birth date:	Nickname:
Home Address:		Home/Work Phone:	
Parent/Guardian:	Emergency Contact Names & Relationship:		
Signature/Consent*:			
Primary Language:	Phone Number(s):		
Physicians:			
Primary care physician:		Emergency Phone:	
		Fax:	
Current Specialty physician:		Emergency Phone:	
Specialty:		Fax:	
Current Specialty physician:		Emergency Phone:	
Specialty:		Fax:	
Anticipated Primary ED:		Pharmacy:	
Anticipated Tertiary Care Center:			

Diagnoses/Past Procedures/Physical Exam:	
1. _____	Baseline physical findings:
_____	_____
2. _____	_____
_____	_____
3. _____	Baseline vital signs:
_____	_____
4. _____	_____
_____	_____
Synopsis:	_____
_____	Baseline neurological status:
_____	_____

*Consent for release of this form to health care providers

*Consent for release of this form to health care providers

Last name:

Diagnoses/Past Procedures/Physical Exam continued:	
Medications:	Significant baseline ancillary findings (lab, x-ray, ECG):
1.	
2.	
3.	
4.	Prostheses/Appliances/Advanced Technology Devices:
5.	
6.	

Management Data:	
Allergies: Medications/Foods to be avoided and why:	
1.	
2.	
3.	
Procedures to be avoided and why:	
1.	
2.	
3.	

Immunizations (mm/yy)											
Dates						Dates					
DPT						Hep B					
OPV						Varicell a					
MMR						TB status					
HIB						Other					

Antibiotic prophylaxis:

Indication:

Medication and dose:

Common Presenting Problems/Findings With Specific Suggested Managements

Problem	Suggested Diagnostic Studies	Treatment Considerations

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

Physician/Provider Signature:

Print Name:

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Estate / Future Planning

Letter of Intent

No one lives forever, not even parents of children with disabilities. Fears about what will happen to your child after you're gone keep you from doing the very thing that will give you peace of mind: Planning. You fear that your child's quality of life may not be the same as they have now. You also know that it should not be left totally up to their sister or brother to care for them. Sometimes the thought of all of this is so overwhelming that you don't even know where to start.

This section is that starting place. It can be a way to facilitate discussion among your family members or just a way to begin organizing your own thoughts and getting them down on paper. You can begin with the less emotional section like the Personal Information before moving on to the more difficult task of choosing a Guardian. Guardianship guidelines vary from state to state. Your attorney can advise you, but not all attorneys are familiar with Special Needs Trusts. A list of attorneys who specialize in this area may be obtained through the national, state or local Arc. Update the plan annually; birthdays are a good time to do this. Don't forget to make copies and give them to all those who should know about your wishes. Planning is a process that takes time, but once you have things decided you will be able to breathe that sigh of relief knowing you no longer have to worry about the future.

Parent/Caregiver Signature_____Date_____

Parent/Caregiver Signature_____Date_____

Notary Information: (Usually your bank, if you are a customer, can notarize this for you, for free.)

Family Information

Mother's Name _____

Maiden Name _____

Social Security Number _____

Address _____

Phone Number _____

Father's Name _____

Social Security Number _____

Address _____

Phone Number _____

Sibling(s)

Name _____

Spouse _____

Address _____

Phone Number _____

Name _____

Spouse _____

Address _____

Phone Number _____

Name _____

Spouse _____

Address _____

Phone Number _____

Name _____

Spouse _____

Address _____

Phone Number _____

Name _____

Spouse _____

Address _____

Phone Number _____

Name _____

Spouse _____

Address _____

Phone Number _____

Names & Addresses of Other Relatives

And whether they have been notified that you have established a Trust so that if they want to leave money to your child/sibling, to leave it to the Trust.

Name _____

Address _____

Phone Number _____

Notified yes no Date notified _____

Name _____

Address _____

Phone Number _____

Notified yes no Date notified _____

Name _____

Address _____

Phone Number _____

Notified yes no Date notified _____

Name _____

Address _____

Phone Number _____

Notified yes no Date notified _____

Name _____

Address _____

Phone Number _____

Notified yes no Date notified _____

Name _____

Address _____

Phone Number _____

Notified yes no Date notified _____

Name _____

Address _____

Phone Number _____

Notified yes no Date notified _____

List of individuals, advocates and/or service providers who touch the life of my child/sibling.

Name_____

Address_____

Phone Number_____

What they typically do with/for my child/sibling

Name_____

Address_____

Phone Number_____

What they typically do with/for my child/sibling

Name_____

Address_____

Phone Number_____

What they typically do with/for my child/sibling

Name_____

Address_____

Phone Number_____

What they typically do with/for my child/sibling

Living Arrangements

Where and in what type of situation would you like to see your child live? Would they live alone or have roommates? What neighborhood? How much supervision would they need?

If currently in a supported living environment, list the following information:

Home Manager
Name and Phone Number _____

Case Manager
Name and Phone Number _____

First Choice of Future Residential Provider

Second Choice _____

Other Service Agencies
(Example: Family Resources, Transportation, etc.)

Agency Name _____
Contact Person _____
Phone Number _____
Reason Used _____

Agency Name _____
Contact Person _____
Phone Number _____
Reason Used _____

Legal / Financial Information

Government/Private Benefits/Assistance
(Example: SSI, Social Security/Disability Insurance)

Type of Benefit _____

Amount _____

Contact Person/Case Worker _____

Department of Human Services Case Worker and Phone Number:

Type of Benefit _____

Amount _____

Other Benefits (currently receiving)
(Example: transportation, cash subsidies/vouchers, utility subsidies)

Other Benefits your child might be entitled to upon your death (Example: Veterans, Railroad)

BANK _____ Branch Location _____

Checking Account Number _____

Safe Deposit box _____

Savings Account Number _____

LIFE INSURANCE

Company _____

Policy number _____

BURIAL POLICY

Funeral Home _____

Cemetery _____

Will & Estate Plans

Letters of Guardianship have been approved by:

Judge _____ Date _____

Approved Guardian's Name _____

Address _____

Phone

Number _____ Relationship _____

Approved Successor Guardians

Name _____

Address _____

Phone

Number _____ Relationship _____

Name _____

Address _____

Phone Number _____ Relationship _____

If a guardian has not been appointed, list in order of preference the people who you would like to serve as guardian, should guardianship prove necessary in the future. Include name(s), address, phone number and the person's relationship to you.

Questions / Concerns / Notes / Additional Information

The End