About This Notebook

2013 Revised Edition

Parents Reaching Out of New Mexico is pleased to present the 2013 Revised Edition of the "Keeping it All Together" notebook, a health and resource organizer for New Mexico's families and their children.

The development of this publication was made possible through a grant from the State of New Mexico Department of Health Public Health Division, Maternal Child and Health Bureau and the University of New Mexico Continuum of Care.

Parents Reaching Out also wishes to acknowledge and credit the New Hampshire Partners in Health, Hood Center for permission to adapt some of their material for this notebook.

"Keeping it All Together" has been the collaborative effort of many people. We would especially like to thank the parents for their comments, expertise and their input and suggestions. They provided us with insights into their experiences and to the very real needs they face day-to-day.

Many of the contributions were either adapted or borrowed with permission from other written materials. We owe a great deal to the University of New Mexico – Continuum of Care; the New Hampshire Partners in Health, Hood Center; and the Managed Care Enhancement Project for Children with Special Health Care Needs, Massachusetts.

To obtain or distribute complete copies of "Keeping It All Together" or to receive information about Parents Reaching Out, call or write us at:

5130 Masthead St NE, Suite C
Albuquerque, NM 87109
505-247-0192 • Fax: 505-247-1345
1-800-524-5176
info@parentsreachingout.org
www.parentsreachingout.org

Parents Reaching Out

Your one stop resource for a stronger family

We are a statewide non-profit 501(c)(3) organization that works with parents, caregivers, educators, and other professionals to promote healthy, positive, and caring experiences for New Mexico families and children. Founded in 1981, we have served families for 30 years.

Our Mission

The mission of Parents Reaching Out is to enhance positive outcomes for families and children in New Mexico through informed decision making, advocacy, education, and resources. Parents Reaching Out provides the networking opportunities for families to connect with and support each other. This mission supports *all families* including those who have children with disabilities, and others who are disenfranchised. Parents Reaching Out achieves this by:

- Developing family leadership
- Connecting families to each other
- Building collaborative partnerships
- Providing families knowledge and tools to enhance their power

Parents Reaching Out offers free:

- **Support and Guidance**. We offer individual help for parents who have concerns about their children's special education programs or need help navigating the health care system. Our parent-to-parent matches provide peer support for families going through similar situations.
  "Thank you for providing support and a caring attitude to families like ours. We can't tell you how much this means to us." – parent
- **Information and Resources**. We provide publications and workshops on early intervention, special education, education, and health care topics for parents and professionals.
  "All the information you provide is priceless to parents." - parent
- **Leadership Opportunities for Parents.** We mentor parents as they share their family stories with policymakers and future teachers, doctors, and health care professionals. Our parent leaders make a difference in communities throughout the state.
  "Thank you for all you do for our community to advocate for our families and students with special needs." - professional

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Dear Parents:

This notebook has been created and designed especially for you. We hope you will use it as a reference guide and organizer as you obtain services and care for your child and family. We also hope that you will find the information, forms and suggestions included to be helpful for you and your family.

You can use this notebook to help you:

- Keep track of your child's medical and developmental history.
- Record changes and details in regards to your child's needs.
- Keep track of questions that you and your child may have.
- Organize the contacts you have with many different people.
- Make it easier for you and your providers to determine who is involved in your child's care.
- Note your concerns and/or the changes that you would like to make in regard to your child's care.

This notebook has been divided into several sections which contain miscellaneous forms to fill in and use with medical and education professionals, as well as and helpful tips on how to reach the goals you have for your child. There are also pocket folders to help you file important information, forms and receipts. Please feel free to personalize this notebook, organizing it in a way that works best for you.

Most importantly, as you and your child begin your journey, please remember that as a parent you are the expert on your child. Your questions are always legitimate and should be thoroughly answered. Your observations are invaluable and ultimately it's up to you and your family to decide what is best for your child.

As parents, we encourage you to find and follow the dreams, hopes and wishes you have for your family. We wish you a journey filled with opportunities for learning, growing, joy and love.

We welcome your comments and/or suggestions. Don't hesitate to contact us at PRO, if we can be of additional help. Our phone number is (800) 524-5176 or (505) 247-0192.

Sincerely,

The Parents Reaching Out Staff

Important Information

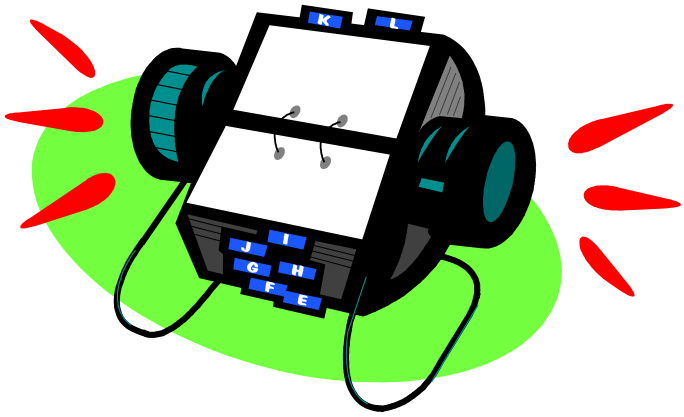
Important Information

Child's Name: _____ Nickname: _____
Address: _____
Social Security Number: _____ Date of Birth: _____
Tribal Census/Enrollment Number: _____
Medical Record Number: _____ Blood Type: _____
Allergies: _____

Parent(s)/Guardian(s)
Name(s): _____ Relationship: _____
Address: _____
Home Phone: _____ Work Phone: _____

Emergency Contact
Name: _____ Relationship: _____
Address: _____
Home Phone: _____ Work Phone: _____

Primary Care Physician
Name: _____ Name of Practice: _____
Address: _____ Phone: _____



In Case of an Emergency*

Hospital/Emergency Room Information

Hospital Name: _____

Address: _____ Phone: _____

Ambulance Services: _____ Phone: _____

Travel Directions: _____

_____

_____

_____

Medical Coverage

Primary Insurance

Policy Number: _____ Contact Person: _____

Address: _____ Phone: _____

Other Insurance

Policy Number: _____ Contact Person: _____

Address: _____ Phone: _____

Who to call in the case of a medical emergency

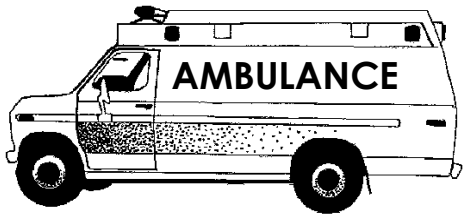
Name: _____Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____Phone: _____

***Remember to take this notebook with you to the hospital/emergency room.**



Your Child and Your Family

All about Me!

Information about the Child

My Name is: _____

My nickname(s) is/are: _____

I live at: □ Home □ School □ Foster Home □ Hospital

□ Other: (Please Specify) _____

Photo of Me

Favorites

Toys: _____

Animals: _____

Games: _____

Hobbies: _____

Songs: _____

TV Shows: _____

Foods: _____

Colors: _____

Movies: _____

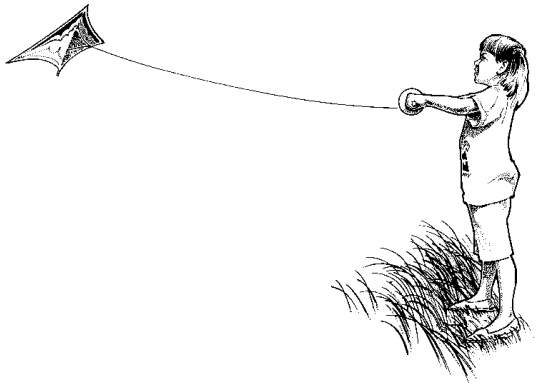
Other: _____

_____

_____

My least favorite foods are: _____

_____



More about Me…

Foods I'm allergic to: _____
Medicines I'm allergic to: _____
Other allergies: _____
_____
_____

My friends are: _____
_____
_____
_____

My pet(s) is/are: _____
Name(s) of pet(s): _____

I usually go to bed at: _____ p.m.
My bedtime routine is: _____
_____
_____

Things I need a little help with: (For example: washing up, brushing teeth, dressing, etc.): _____
_____
_____
_____

Things I can do on my own: _____
_____
_____
_____
_____

If you need to know anything else, just ask me!

Child's Birth History

Child's Name: _____ Date of Birth: _____

Method of Birth

□ Vaginal □ Cesarean □ Breach

Any complications: _____

_____

_____

_____

Mother's Ob/Gyn: _____ Phone: _____
Child's Pediatrician at Birth: _____ Phone: _____

Place of Birth
Name of Hospital: _____
Address: _____ Phone: _____
Transferring Hospital: _____
Address: _____ Phone: _____

About the Baby
Birth Weight: _____ Length: _____

Baby was: □ Full Term □ Premature_____ Months of gestation

Child's Apgar scores at one (1) minute were: ___ at five (5) minutes: _____

Child's age at first discharge from hospital: _____

About the Mother

Mother's age at onset of pregnancy: _____

Complications during the pregnancy: _____

_____

_____

_____

_____

_____

Complications during any previous pregnancies: _____

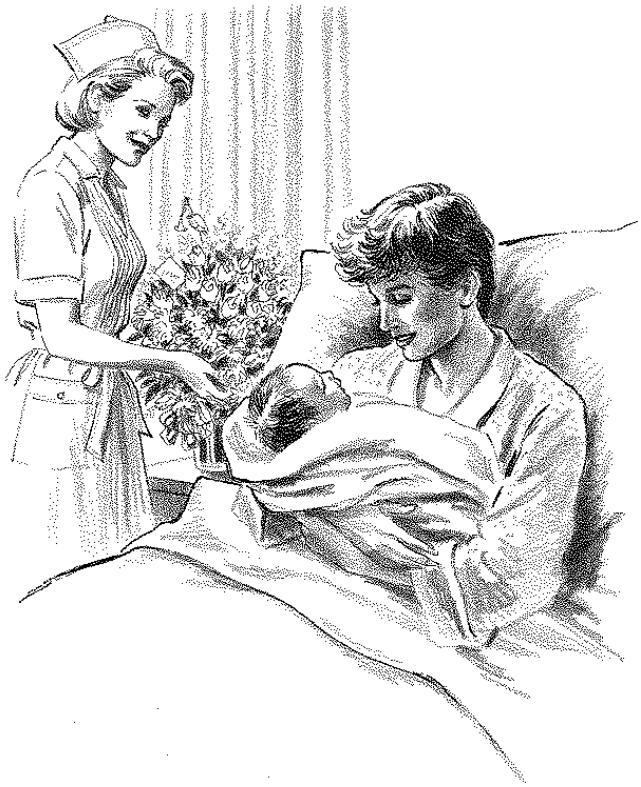
_____

_____

_____

_____

_____



Family Information

Childs Name:_____ SSN*: _____
DOB**: _____ Place of Birth: _____
Address: _____
Mothers Name: _____ SSN: _____
DOB: _____ Place of Birth: _____
Address: _____
Home Phone: _____ Work Phone: _____
Fathers Name: _____ SSN: _____
DOB: _____ Place of Birth: _____
Address: _____
Home Phone: _____ Work Phone: _____

Other Immediate Family Members

First Name:	Last Name:	Relationship:	DOB:	SSN:

Other Significant Family Members/Friends

First Name:	Last Name:	Relationship:	Phone Number:

***SSN**—Social Security Number
****DOB**—Date of Birth

Family Health History

Child's Name: _____DOB: _____

Is there anyone in the family with similar health issues/allergies/diagnoses? □ Yes □ No
If yes, whom?: _____
_____

Does anyone in the family (such as a parent, sibling, grandparent, aunt, uncle, cousin etc.) have any of the following:

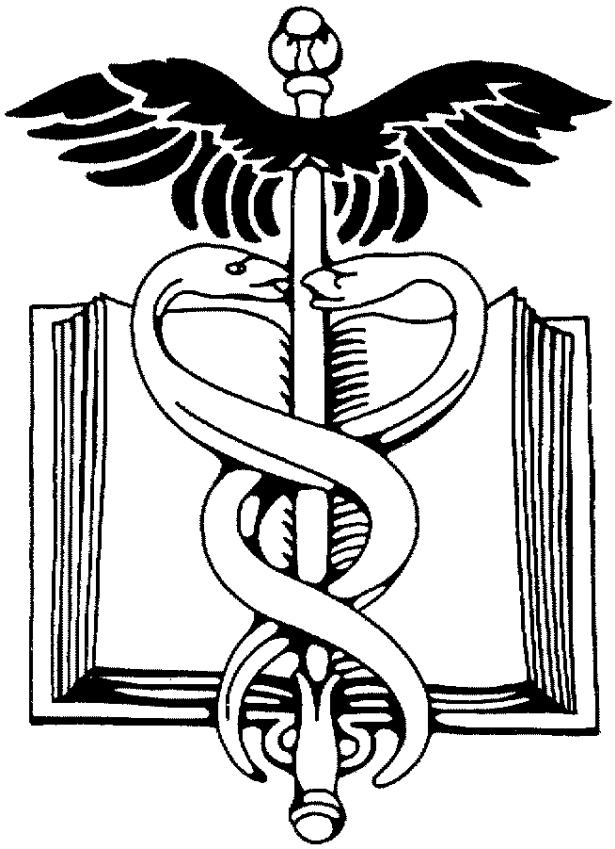
			If yes, relationship to the child:
1. Cerebral Palsy	□ Yes	□ No	_____
2. Heart Problem	□ Yes	□ No	_____
3. Developmental Disability	□ Yes	□ No	_____
4. Seizure Disorder	□ Yes	□ No	_____
5. Diabetes	□ Yes	□ No	_____
6. Blood Disorder	□ Yes	□ No	_____
7. Cancer	□ Yes	□ No	_____
8. Vision/Hearing Impairment	□ Yes	□ No	_____

Other: _____
_____
_____

Has the family had genetic counseling? □ Yes □ No

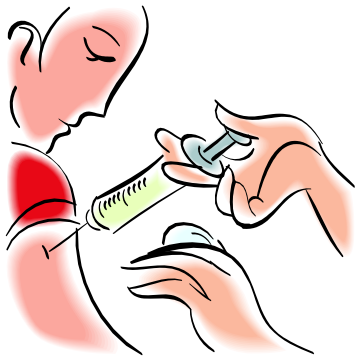
Other information that might be helpful to know about the family's health history: _____
_____
_____
_____
_____

Health Records



Immunization Records

Immunization: (Vaccine)	Date Received:	Administered by: (Name of Doctor/Nurse)	Place: (Name of Clinic)
Hepatitis B	1. 2. 3.		
DtaP (Diphtheria, Tetanus, Pertussis)	1. 2. 3.		
Td (Tetanus, Diphtheria)	1. 2. 3.		
Hib (Haemophilus Influezae B)	1. 2. 3.		
Polio	1. 2. 3.		
MMR (Measles, Mumps, Rubella)	1. 2.		
Varicella (Chickenpox)	1. 2.		
Other	1. 2. 3.		

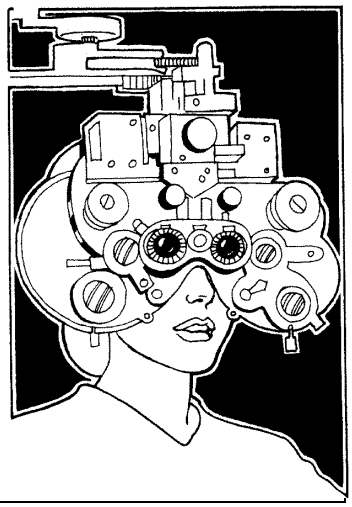


Height and Weight Records

Date:	Age:	Height:	Weight:	Blood Pressure:

Routine Healthcare Exams/Screenings

Vision



Date:	Age:	Results/Recommendations:

Hearing

Date:	Age:	Results/Recommendations:

Other Exams/Screenings

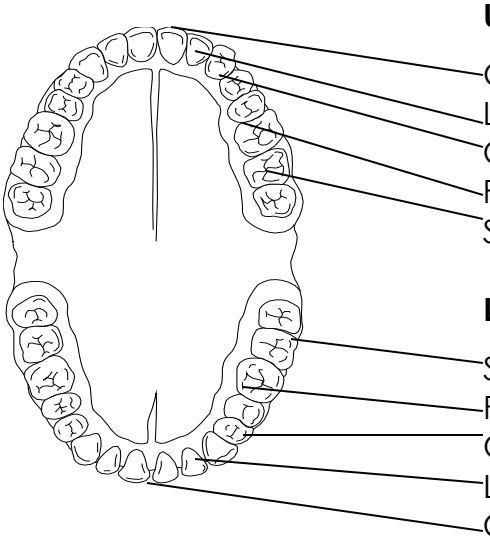
Date:	Age:	Results/Recommendations:

Record of Important Tests

Test: _____ Date Performed: _____
Description of Test: _____
Ordered by (Doctor's Name): _____
Results: _____
_____
_____
Records of the test are located at/with:
□ Doctor noted above
Address: _____ Phone: _____
□ Other: _____
Address: _____ Phone: _____
Comments: _____
_____
_____
_____

Test: _____ Date Performed: _____
Description of Test: _____
Ordered by (Doctor's Name): _____
Results: _____
_____
_____
Records of the test are located at/with:
□ Doctor noted above
Address: _____ Phone: _____
□ Other: _____
Address: _____ Phone: _____
Comments: _____
_____
_____
_____

My Child's Teeth and Dental Care



Upper Primary Teeth	Eruption	Shedding
Central Incisors	7 months	7 years
Lateral Incisors	9 months	8 years
Cuspids	18 months	11 years
First Molars	14 months	10 years
Second Molars	24 months	10 years

Lower Primary Teeth	Eruption	Shedding
Second Molars	20 months	11 years
First Molars	12 months	10 years
Cuspids	16months	9 years
Lateral Incisors	7 months	7 years
Central Incisors	6 months	6 years

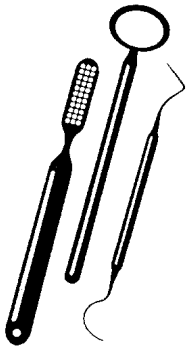
Eruption Dates of Primary Teeth

Upper	Date:	Lower	Date:
Central Incisors		Central Incisors	
Lateral Incisors		Lateral Incisors	
Cuspids		Cuspids	
First Molars		First Molars	
Secondary Molars		Secondary Molars	

Visits to the Dentist

Most dentists recommend that you take your child for his or her first visit between the ages of two (2) and three (3) years for a pleasant introduction.

Date of Visits:	Age:	Doctor's Comments/Treatments:



Childhood Illnesses

Illness:	Date:	Age:
Chickenpox		
Measles		
German Measles (Rubella)		
Mumps		
Roseola		
Whooping Cough (Pertussis)		

Common Infections
(Ear, throat, sinus, urinary, etc.)

Date:	Age:	Type of Infection/s:	Treatment/s:	Comments:

Asthma and Other Respiratory Conditions

(Bronchitis, Pneumonia, wheezing, etc.)

Date:	Age:	Type of Condition/s:	Treatment/s:	Comments:

Allergies

(Skin, food, medications, etc.)

Date:	Age:	Type of Allergies/Reactions:	Treatment/s:	Comments:

Record of Injuries, Accidents & Emergencies

Date: _____

Description of incident: _____

_____

_____

Treated by: _____

Address: _____ Phone: _____

Description of Treatment: _____

_____

Follow-up: _____

_____

Date: _____

Description of incident: _____

_____

_____

Treated by: _____

Address: _____ Phone: _____

Description of Treatment: _____

_____

Follow-up: _____

_____

Date: _____

Description of incident: _____

_____

_____

Treated by: _____

Address: _____ Phone: _____

Description of Treatment: _____

_____

Follow-up: _____

_____

Authorization for Release of Medical Records

I give permission for: (name) _____
to release: (type of information) _____
with the exception of: (type of information) _____
to: (name) _____
for the purpose of: (reason for releasing information) _____
_____
_____
This release is in regards to: (child's name) _____
Address: _____Phone: _____
Hospital/Medical Record/Clinic ID #: _____
This authorization is good until: (date) _____

Signature: _____ Date: _____

Print Name: _____ Relationship to child: _____

Growing Up

This chart outlines the typical development of most children and the age at which most children do certain things. However, please know that while most typically developing children accomplish these tasks around the listed age, some may do them a little earlier or later.

	Social	Language	Movement	Body Use
3 Months	Laughs and makes "happy" sounds. Turns head to sounds.	Smiles at familiar people and reaches for familiar people/toys.	Supports/pushes self up on arms when lying on stomach.	Can steadily hold head up. Pulls at clothing.
6 Months	Outstretches arms in order to be picked up & likes to look at self in mirror.	Repeats sounds and/or squeals out loud.	Rolls from back to front and is beginning to "creep".	Picks up small objects & transfers toys from hand-to-hand.
9 Months	Plays "Peek-a-Boo" & "Patty Cake". Holds own bottle.	Waves "bye-bye". Imitates sounds or words heard.	Sits up alone. Pulls up on furniture.	Eats finger foods. Picks up objects with thumb & one finger.
12 Months	Comes when called to. Tries to help with dressing.	Says at least one real word. Shakes head "No".	Walks alone or with hand held. Turns when sitting down.	Can throw toys/roll a ball.
18 Months	Copies adult chores while playing. Explores surroundings.	Says at least 6 real words. Points to things he/she wants.	Walks upstairs with help. Can pull wheeled toys.	Scoops & feeds self with spoon. Turns 2-3 pages in a book.
2 Years	Asks to go to the toilet. Can tell their *first* name when asked	Talks in 2-3 word sentences. Uses "no"/"not" in speech.	Runs without falling. Walks up and down stairs without help.	Takes off socks, shoes, pants & shirt without help.
2 ½ Years	Can get a drink without help. Sings/dances to music.	Holds up fingers to tell age. Uses "I" in speech.	Jumps using both feet. Can throw a ball.	Can button and unbutton.
3 Years	Asks about people or things. Can take turns. Can tell their *full* name when asked.	Tells about things that happened to himself/herself. Can point to most body parts.	Goes upstairs, alternating feet. Pedals a tricycle.	Holds pencil or crayon correctly. Dresses and undresses with help.
4 Years	Plays well in small groups. Likes to "show-off".	Knows most colors. Can recite a song or poem without help.	Tries to hop or skip. Walks down stairs, alternating feet.	Cuts with scissors.
5 Years	Likes to do things for others.	Asks what words mean. Can recite address and phone number.	Skips and jumps.	Prints first name. Ties own shoes.

All children develop at different rates. If your child is not doing one of the activities on the chart, there is probably no need for concern. However, if your child is late in doing several activities and you are interested in having his vision and hearing checked and finding out how he is progressing in speech, language and motor development a free Child Find Screening can be scheduled for children aged three and older. Call your local school district and ask for the Child Find Office. For those younger than three, see page 26.

If You Are Concerned about Your Child's Development

If your child is less than three years old, he or she might be eligible for Early Intervention services. Early Intervention is a program for children between birth and age three, who currently have or are at risk of having a developmental delay; that is, children who develop differently or at a slower rate than most other children. A child with a developmental delay may have more difficulty than other children in learning to crawl, walk, or communicate.

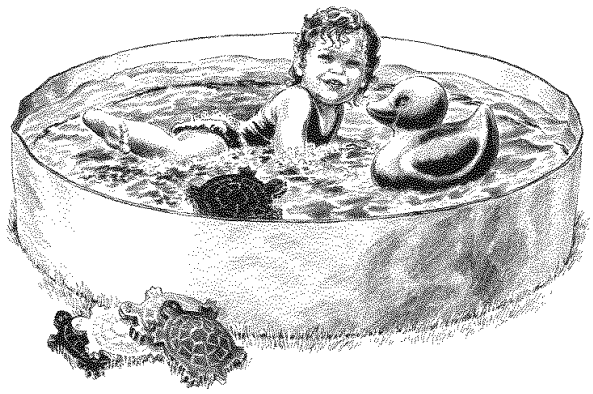
Getting help early can make a big difference in your child's life. The purpose of Early Intervention is to help parents recognize and understand what their child's particular developmental needs are, and to teach them ways to help their child.

Examples of children who may be eligible for Early Intervention services include children who:

- Are born prematurely;
- Have feeding, vision, or hearing problems;
- Are slow to sit up, stand, walk, talk, or do things for themselves;
- Have behavior or attention difficulties; or
- Are born with a disability or health condition that affects their development.

If you think your child might need Early Intervention services, discuss your concerns with your child's primary care physician. A developmental evaluation can be scheduled in order to determine whether your child would benefit from Early Intervention services and whether or not he or she is eligible to receive these services.

Parents may also refer their child for an Early Intervention evaluation without a visit to the physician first. For more information about Early Intervention please call Parents Reaching Out toll free at 1-800-524-5176 or Babynet at 1-800-552-8195.

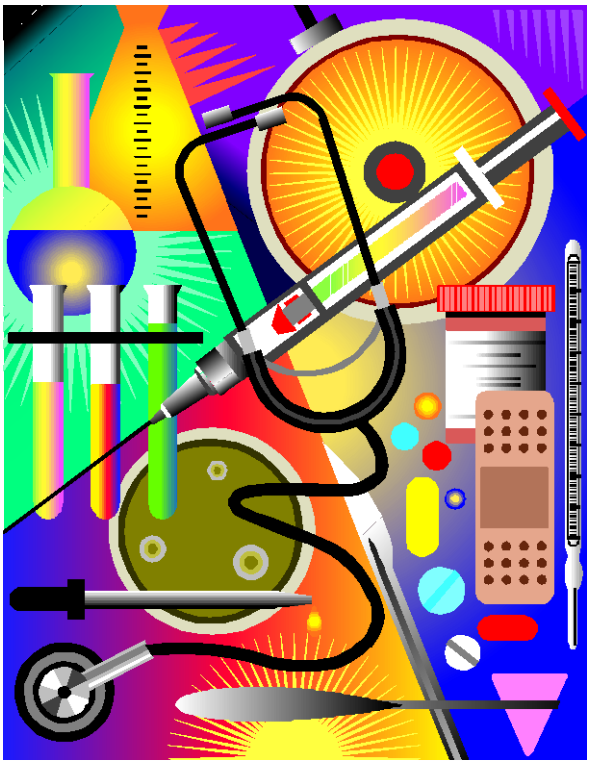


Milestones

How old was your child when the following actions/activities first occurred or were learned? Use this page to not only record significant dates, but to record answers to some commonly asked questions parents have.

Activity:	Age of Child:	Questions/Comments:
Hold head up		
Rolls over back to front		
Sat unassisted		
Crawled		
First word		
First 2—3 word sentence		
Walked without holding on to anything		
Began toilet training		
Toilet Trained (Bladder)		
Toilet Trained (Bowel)		
Began feeding his/herself		
Stopped drinking from a bottle		
Other		

Current Health Care Information



Health Care Providers by Specialization*

Primary Care Providers: Physicians, Nurse Practitioners (NP)
Adult Primary Care Providers: Internists, Adult Nurse Practitioners (ANP), Family Practitioners (FP), Family Nurse Practitioners (FNP), Geriatric Nurse Practitioners (GNP)
Pediatric Primary Care Providers: Pediatricians, Pediatric Nurse Practitioners (PNP) Family Practitioners (FP), Family Nurse Practitioners (FNP)

Specialization	Physician	Non-Physician Specialist
Eyes/Vision	Ophthalmologist	Optometrist
Ears/Hearing	ENT (Otolaryngologist)	Audiologist
Nose & Throat	ENT (Otolaryngologist)	
Nervous System	Neurologist	
Emotion/Behavior	Psychiatrist Behavioral Neurologist	Psychopharmacologist, Psychologist, Psychiatric Nurse, Social Worker
Heart	Cardiologist	
Stomach, Colon, Intestines	Gastroenterologist	
Skin	Dermatologist, Plastic Surgeon	
Lungs/Chest	Pulmonary Specialist	Respiratory Therapist
Bones/Tendons	Orthopedist, Physiatrist	
Kidney	Nephrologist	
Urinary Tract	Urologist	
Blood	Hematologist	
Hormones	Endocrinologist	
Reproductive Health	Gynecologist, Obstetrician	Nurse/Midwife
Foot Care	Podiatrist	
X-Ray	Radiologist	
Head/Neck/Back	Physiatrist	Chiropractor, Physical Therapist
Diet/Nutrition		Dietitian, Nutritionist
Mental Health	Psychiatrist	Psychologist, Social Worker

* The type of work they do (specialize in).

Questions, Questions, Questions

Sometimes it is hard to remember everything, or think of what you need to ask your child's doctor. The following are some sample questions to help you get on the right track.

Questions about Illnesses

- When will my child begin to feel better? What are the indications that he/she is getting better? What are the indications of any complication or worsening?
- Are there symptoms I should be aware of in order to properly monitor this illness?
- If I do notice any signs of complications, how can I contact you after hours? In case of an emergency, whom should I call?
- When can he/she go back to school? Are there any special precautions, which the school should be aware of?

Questions about Medications

- When should I give this medication?
- When the prescription says "three times a day" does that mean every 8 hours including during the night, or three times during the daytime?
- When my child goes back to school, will he need to take this medicine during school hours or can it wait until he goes home at (specify time) to take it?
- Should my child take this medication before, during, or after meals?
- Are there any foods, which should not be mixed with this medication?
- Can my child take this medicine with other medications?
- Are there any possible side effects or allergic reactions of which I should be aware?

Questions about Tests

- What do you expect to learn from these tests?
- Have these tests been given to my child before? Can we coordinate any of the earlier results with these?
- Does the school or public health clinic also do these tests? Are there any reasons not to have them done there to save on expenses?
- How long will these tests take and what is involved in them?
- Is there anything I should tell my child about these tests which will help prepare him/her?
- Can he/she eat before the test?
- Are there any precautions I should take before, during or after these tests?

Questions to Ask about Referrals to Specialists

- Specifically, why is this referral being made? Is this for a second opinion or are we seeing the specialist for a diagnosis?
- Are there records I should take with me or will they be sent in advance?
- Who will get the reports of this evaluation? Who will be interpreting them? Who will be discussing these reports with me?

My Child's Primary Healthcare Providers

Primary Physician

Name: _____

Address: _____ Phone: _____

Nurses Name: _____

Dentist

Name: _____

Address: _____ Phone: _____

Pharmacy

Name: _____

Address: _____ Phone: _____

Hospital

Name: _____

Address: _____ Phone: _____

Patient ID: _____ Emergency Room #: _____

Other Healthcare Providers

Name: _____ Title: _____

Address: _____ Phone: _____

Other Providers Who Care for My Child

(School, Daycare, WIC, Headstart, Early Intervention, Service Coordinator, Public Health Nurse, etc.)

Name: _____
Address: _____ Phone: _____
Services Provided: _____

Name: _____
Address: _____ Phone: _____
Services Provided: _____

Name: _____
Address: _____ Phone: _____
Services Provided: _____

Name: _____
Address: _____ Phone: _____
Services Provided: _____

Name: _____
Address: _____ Phone: _____
Services Provided: _____

Name: _____
Address: _____ Phone: _____
Services Provided: _____

Name: _____
Address: _____ Phone: _____
Services Provided: _____

Name: _____
Address: _____ Phone: _____
Services Provided: _____

Phone Log

Date/Time: _____Person Called: _____
Summary of conversation: _____
_____
_____
_____
_____
_____

Date/Time: _____Person Called: _____
Summary of conversation: _____
_____
_____
_____
_____
_____

Date/Time: _____Person Called: _____
Summary of conversation: _____
_____
_____
_____
_____
_____

Date/Time: _____Person Called: _____
Summary of conversation: _____
_____
_____
_____
_____

Visit Notes

Before the visit

Date: _____ Doctor: _____

Reason for appointment/visit: _____

_____

_____

Medication/s child is currently taking: _____

_____

Allergies/Reactions: _____

_____

Symptoms (what they are and how long the child has had them): _____

_____

_____

Other questions/concerns: _____

_____

_____

_____

Visit Results

Outcome: _____

Medications Prescribed (names, dosage, side effects, etc.): _____

_____

Other Special Instructions (treatments, how often, how long, etc.): _____

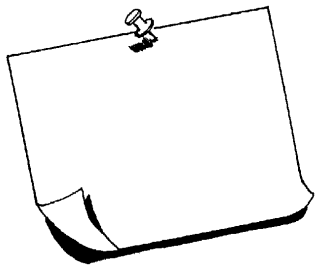
_____

_____

Follow-up/Referrals Needed: _____

_____

Date of next appointment: _____



Visit Notes

Before the visit

Date: _____ Doctor: _____

Reason for appointment/visit: _____

_____

_____

Medication/s child is currently taking: _____

_____

Allergies/Reactions: _____

_____

Symptoms (what they are and how long the child has had them): _____

_____

_____

Other questions/concerns: _____

_____

_____

_____

Visit Results

Outcome: _____

Medications Prescribed (names, dosage, side effects, etc.): _____

_____

Other Special Instructions (treatments, how often, how long, etc.): _____

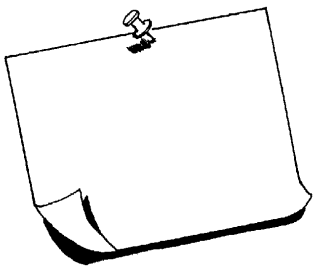
_____

_____

Follow-up/Referrals Needed: _____

_____

Date of next appointment: _____



Medication Log

(Prescription and/or over the counter)

Date:	Medication:	Dose:	How often:	Purpose:
Prescribed by:				

Date:	Medication:	Dose:	How often:	Purpose:
Prescribed by:				

Date:	Medication:	Dose:	How often:	Purpose:
Prescribed by:				

Home Health Agency

Services to be Provided
(Nursing, therapy, home health aides, etc.)

Agency Name: _____ Contact Person: _____
Address: _____ Phone: _____

Service	**Frequency (How often per week)**	**Amount (Hours per week)**
	Visits per week	Hours per visit
	Visits per week	Hours per visit
	Visits per week	Hours per visit
	Visits per week	Hours per visit
	Visits per week	Hours per visit

Agency Name: _____ Contact Person: _____
Address: _____ Phone: _____

Service	**Frequency (How often per week)**	**Amount (Hours per week)**
	Visits per week	Hours per visit
	Visits per week	Hours per visit
	Visits per week	Hours per visit
	Visits per week	Hours per visit
	Visits per week	Hours per visit

Supplies & Equipment

Description of item: ______________________________
Provider/Vendor Name: ______________________________
Contact Person: ______________________ Phone: __________
Prescribed by: ______________________ Phone: __________
Reason Prescribed: ______________________________
____
Service Contact Person: ______________________ Phone: __________
Comments: ______________________________
____
____

Description of item: ______________________________
Provider/Vendor Name: ______________________________
Contact Person: ______________________ Phone: __________
Prescribed by: ______________________ Phone: __________
Reason Prescribed: ______________________________
____
Service Contact Person: ______________________ Phone: __________
Comments: ______________________________
____
____

Description of item: ______________________________
Provider/Vendor Name: ______________________________
Contact Person: ______________________ Phone: __________
Prescribed by: ______________________ Phone: __________
Reason Prescribed: ______________________________
____
Service Contact Person: ______________________ Phone: __________
Comments: ______________________________
____
____

Phone Log

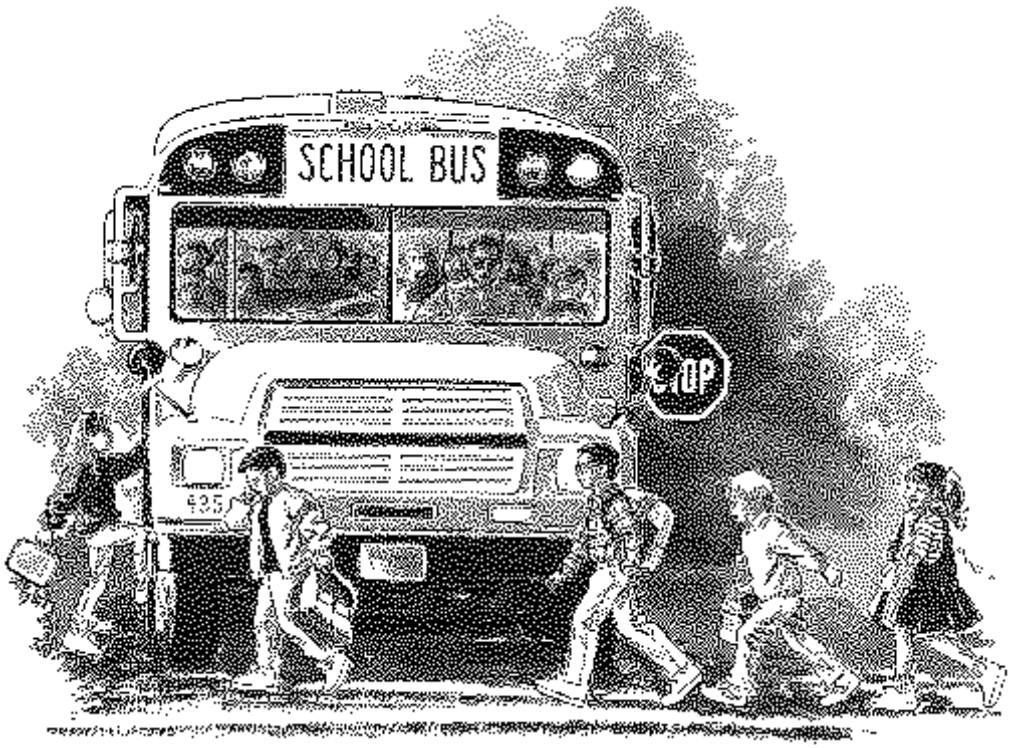
Date/Time: _____Person Called: _____
Summary of conversation: _____

Date/Time: _____Person Called: _____
Summary of conversation: _____

Date/Time: _____Person Called: _____
Summary of conversation: _____

Date/Time: _____Person Called: _____
Summary of conversation: _____

School Information



What You Need to Know about Keeping School Records

Keep a file for each year your child is in school. Be sure it includes:

- The name of the school or program
- The schools address and phone number
- The name of the Principal and/or other administrators
- The names of your child's teachers
- The name of the psychologist (if any) and why there was a referral to a psychologist
- The names of any related service people who work with your child

You will also want to include any reports the school or program writes about you child, such as Individual Family Service Program (IFSP), Individualized Education Program (IEP), evaluations, tests, therapy reports, report cards or verbal reports. If the school writes to you about your child, or if you write to the school system about your child, keep a copy of the correspondence. If reports are developed by the school or at the school system's request, be sure to get a copy for your files.

- You have a right to have copies of any information written about your child. **EVERYTHING REPORTED ABOUT YOUR CHILD IS LEGALLY AVAILABLE TO THE PARENTS OR PRIMARY CARETAKERS OF THAT CHILD.** Collect all such information for your home records. If you child is in secondary school, this is especially important since many schools destroy files shortly after the student leaves the school system.

- If you talk to school staff by phone or meet with them, it is always helpful to make a note to yourself about the date and subject of the conversation. File this note in your school records file. If this is an especially important conversation, it may be a good idea to follow it up with a letter restating the subject and any decisions made. A follow-up letter ensures that both parties understand the issue(s) discussed during the conversation as well as the agreed upon action(s) to be taken.

- Your child's school or educational program, at any age level, will send home progress reports. This may include report cards, IEP evaluations, regularly scheduled test results, and informal reports from teachers and therapists. *All of these should be filed*. In addition, school systems may conduct a variety of other assessments. In such instances, you will be asked to sign a written permission form before such testing is conducted. Copies of these consent forms, as well as the results of such tests should also become part of your child's school records.

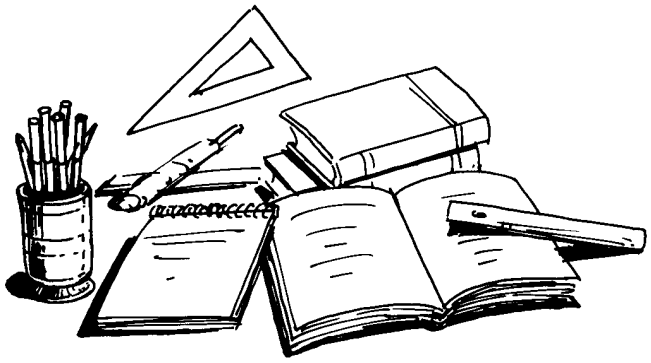
- You have the right to ask for and receive a list of the types of school records kept on your child. The school will give you information on where the records are kept, how you can see them and how you can get a copy of them. There may be a small fee for duplicating these papers. If you would like to see or get a copy of your child's records, you can make a request in writing to the local school district. A sample letter is located at the end of this section.

- No one outside your child's school or program has access to your child's records without your written permission. You may notify the school that you do not give permission for anyone outside the system to use these records for any reason. Your rights are based on two federal laws. The first is the Family Education Rights and Privacy Act of 1974. This law applies to the records of all school children. The second law is the Education for All Handicapped Children Act of 1975. This law is also known as Public Law 94-142. In recent years several amendments have been added to the Act, so you may hear people refer to other numbers or names. (I.D.E.A.)

- When a child graduates or finishes public school, all records may be destroyed after a short time. However, even after a person has finished his or her schooling, prospective employers, post-secondary programs or rehabilitation facilities still may request their records.

- School systems have written guidelines concerning record keeping and privacy policies. You can request information on policies in your school district if you have any questions or concerns. Most state departments of education can also provide you with this type of information.

- Be sure to keep your home file current. It can be extremely valuable to you to do this for many reasons. If you move to another school all this information will be necessary to establish a program in the new school. Also, during assessments of your child's progress, the files will provide a history of developmental gains and losses, and will help point out any developmental patterns.



School Information

Date: _____ School Year: _____
Name of School: _____
Address: _____ Phone: _____
School Identification Number: _____
Principal _____ Phone: _____
Assistant Principal: _____ Phone: _____
Nurse: _____ Phone: _____
Social Worker: _____ Phone: _____
Cafeteria: _____ Phone: _____
Other: _____ Phone: _____
Other: _____ Phone: _____

Teacher: _____ Room #: _____ Phone: _____
Teacher: _____ Room #: _____ Phone: _____
Teacher: _____ Room #: _____ Phone: _____
Teacher: _____ Room #: _____ Phone: _____
Teacher: _____ Room #: _____ Phone: _____
Teacher: _____ Room #: _____ Phone: _____
Teacher: _____ Room #: _____ Phone: _____

Bus Driver's Name: _____ Bus #: _____ Phone: _____
Bus Driver's Name: _____ Bus #: _____ Phone: _____

After School Programs

(Leisure & Recreational)

Activity: ______________________________ Agency: ______________
Address: ______________________________ Phone: ______________
Contact Person: ________________________ Hours: ______________

Activity: ______________________________ Agency: ______________
Address: ______________________________ Phone: ______________
Contact Person: ________________________ Hours: ______________

Activity: ______________________________ Agency: ______________
Address: ______________________________ Phone: ______________
Contact Person: ________________________ Hours: ______________

Activity: ______________________________ Agency: ______________
Address: ______________________________ Phone: ______________
Contact Person: ________________________ Hours: ______________

Activity: ______________________________ Agency: ______________
Address: ______________________________ Phone: ______________
Contact Person: ________________________ Hours: ______________

Activity: ______________________________ Agency: ______________
Address: ______________________________ Phone: ______________
Contact Person: ________________________ Hours: ______________

Activity: ______________________________ Agency: ______________
Address: ______________________________ Phone: ______________
Contact Person: ________________________ Hours: ______________

Activity: ______________________________ Agency: ______________
Address: ______________________________ Phone: ______________
Contact Person: ________________________ Hours: ______________

Other after School Services

(Occupational therapy, physical therapy, speech, etc.)

Service: _____ Provider: _____
Address: _____ Phone: _____
Therapy days: _____ Times: _____

Service: _____ Provider: _____
Address: _____ Phone: _____
Therapy days: _____ Times: _____

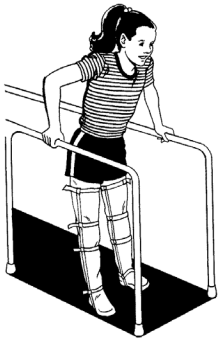
Service: _____ Provider: _____
Address: _____ Phone: _____
Therapy days: _____ Times: _____

Service: _____ Provider: _____
Address: _____ Phone: _____
Therapy days: _____ Times: _____

Service: _____ Provider: _____
Address: _____ Phone: _____
Therapy days: _____ Times: _____

Service: _____ Provider: _____
Address: _____ Phone: _____
Therapy days: _____ Times: _____

Service: _____ Provider: _____
Address: _____ Phone: _____
Therapy days: _____ Times: _____



Phone Log

Date/Time: _____Person Called: _____
Summary of conversation: _____
_____
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Date/Time: _____Person Called: _____
Summary of conversation: _____
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Date/Time: _____Person Called: _____
Summary of conversation: _____
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_____
_____

Date/Time: _____Person Called: _____
Summary of conversation: _____
_____
_____
_____
_____
_____

If You Are Concerned about Your Childs Ability to Learn…

If you have concerns about your child's development or his/her ability to learn in school due to:

- A physical condition (vision, hearing, etc.)
- A behavior problem
- A medical problem
- Inability to pay attention
- Or some other reason…

***And* you think that your child would benefit from special education and related services, such as:**

- Support and help in the regular classroom and related services if needed
- Special education assistance for part of the day and related services if needed
- A special education class for most of the school day and related services

You can request that the school district evaluate your child to determine if your child qualifies for special education program and/or related services.

How to Request an Evaluation:

- Write a letter to the principal of your child's school. Be sure to date that letter. (See attached sample letter.)
- Send a copy of the letter to the special education administrator of the school district where your child attends school and remember to keep a copy of the letter for your files.

If your child has difficulty in:

- Writing
- Doing physical activities
- Hearing
- Paying attention
- Finding his/her way around school
- Seeing
- Or doing any other school related activity…

Add that information to you letter and request that the school district do specific evaluations in more areas. Example: difficulty writing—request and occupational therapy evaluation.

Mark your calendar on the day that you mail the letter.

- The school district must evaluate your child within a reasonable time after they receive your request.
- The New Mexico State special education regulations require that you be a part of the evaluation process of your child.
- The school district must provide some way for you to have input, using a form, phone call or meeting.

School District Initiated Evaluations

The school district may also decide that your child should be evaluated. They must have written permission from you before they can do the first evaluation of your child.

Sample Letter Requesting an Evaluation

Your Address
Your Phone Number

Date

Principal's Name
Name of Child's School
Address

Dear Mr./Mrs. _____:

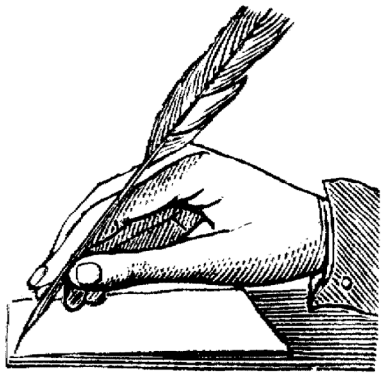
I am the parent of _____, whose date of birth is_____and who is a student in the_____grade at _____school.

My child has not been doing well in school and I believe _____may need special education services. I am therefore requesting a complete Multidisciplinary Team (MDT) evaluation to determine if _____is an exceptional child and, if so, what programs and services are needed. I understand that under state regulations, I am a member of the MDT; please let me know when the MDT will meet so that I may attend.

I hereby give my consent for the evaluation to be done. I understand that under state regulations, the evaluation must be completed in a timely manner from the date of my consent.

Should you have any questions or problems with this request, please feel free to contact me.

Thank you.

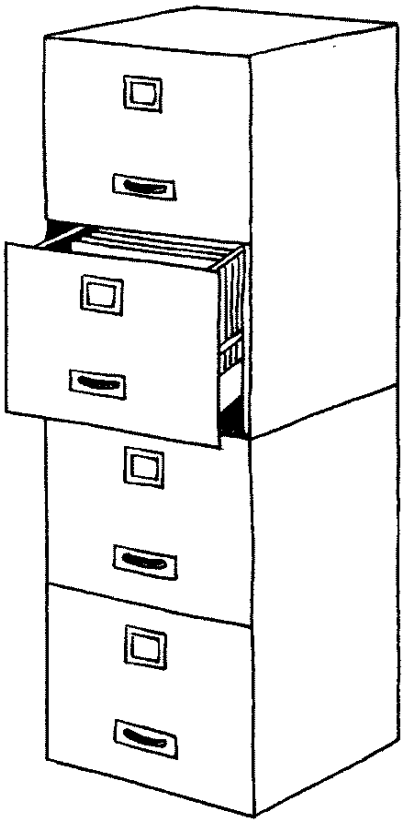


Sincerely,

Your Name

cc: Special Education Director

Additional Organizers



Choosing a Sitter

Every parent needs some down time from childcare and your child can also benefit from seeing a new face every once in awhile. For some families, a teenaged neighbor might be fine. For other families, someone with clinical expertise (such as a nurse) is better. Always make sure to tell any sitter about your child's care needs, and provide basic training for them. Your sitter should be mature and alert enough to deal with emergencies. Here are a few suggestions to help you find a sitter best suited for your family:

- **Friends or other family members** may be willing to care for your child. If so, let them watch you take care of your child. This will help them learn to care for your child when you're away.

- **Put an ad in your local newspaper.** Be sure to state the qualifications needed and any specific needs you or your child has.

- **Contact churches and parent groups** in your area**.** Ask if they have a list of babysitters. Other parents may also be willing to sit for your child. Some parents form "babysitting co-ops" to exchange childcare services.

- **Call a local nursing school or a community college** with a healthcare training program. Students in these programs may be available to baby-sit.

- **If you need someone with clinical training,** call a local hospital. Ask if there are any part-time or retired staff that baby-sit. You might also ask if you can post a note for a "special" sitter on the hospital's bulletin board.

- **If your child has special health care needs** look for someone who is comfortable with and can handle all of your child's equipment and special care needs.

- **Use the form on the next page** to give your sitter important information.

Important Information for Your Child's Sitter

(Keep this form readily available for your child's sitter in case of an emergency.)

Emergency Medical Service (EMS) Phone: _____

Child's Name: _____ Date of Birth: _____

Address: _____

Directions to house: _____

_____

_____

Primary Care Physician: _____ Phone: _____

Significant events during the past 48 hours: _____

_____

_____

Medication(s) to be given and time(s): _____

_____

_____

Allergies: _____

Extra equipment/supplies are located: _____

_____

Fuse box or breaker is located: _____

_____

Flashlight is located: _____

We will be at: _____

The telephone number is: _____

We will be home around: _____

Special Instructions: _____

_____

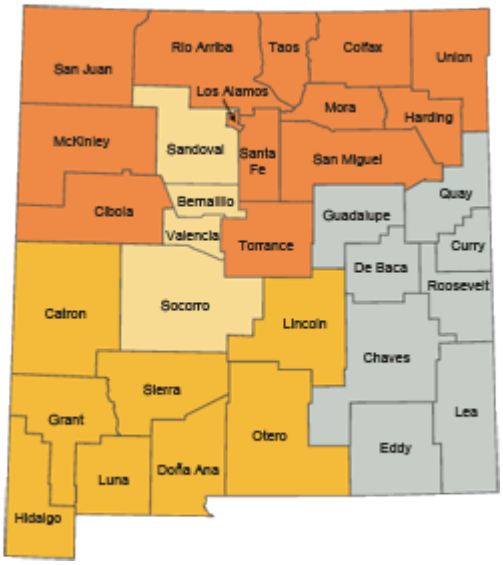
_____

_____

Training & Technical Assistance Programs (TTAPs)

Training, support, and technical assistance programs serve families and childcare professionals working in childcare centers, family childcare homes and before and after school programs in all counties in the State of New Mexico. Some of the services offered by TTAPs to families include childcare referrals and information about identifying high quality care and education programs.

In addition, the TTAPs, as well as their toy and resource lending libraries, are available to parents/guardians and childcare providers. Specialized services are provided to TANF/JTPA/WIA participants by most TTAPs. Aim High, a pilot project offered by all TTAPs, receives funding from the Children, Youth & Families Department, and all services provided by TTAPs are free. TTAPs also strive to coordinate their efforts with community agencies, institutions of higher education, employers and state entities, and to collect and share data useful to leaders and policy makers at the community, state and federal level as part of an advocacy effort to improve the lives of children, families, and child care professionals.



ENMU Child Care Training and Technical Assistance Program
1500 S. Ave K
Quay Hall, Station #9
Portales, NM 88130
Phone: (575) 562-2850
Fax: (575) 562-2305

UNM Northern TTAP Training and Technical Assistance Program
115 Civic Plaza Drive
Taos, NM 87571
Phone: (575)737-3735
Fax: (575)737-3728

UNM Cariño Early Childhood Training and Technical Assistance Program
UNM Continuing Ed
Cariño Early Childhood TTAP
1634 University Blvd. NE
Albuquerque, NM 87102
Phone: (505) 277-1262
Fax: (505) 277-8975

WNMU La Familia Resource Center
WNMU
P.O. Box 680
513 W. 12th Street
Silver City, NM 88062
Phone: (575) 538-6481
Fax: (575) 538-6482

Resource Contact Sheets

Problem/Topic: _____

Name of agency contacted: _____

Name of contact person, or person you spoke with:

Date you called: _____ Phone: _____

Results of discussion: _____

_____

_____

_____

_____

_____

Action taken (if any): _____

_____

_____

_____

_____

Was this person helpful on this topic?

□ Yes □ No

If no, list other topics, areas, issues, etc. in which you feel this person or agency may be helpful in the future: _____

_____

_____

_____

_____

_____

Phone Directory

Name :	Address:	Phone:

Additional Copies of All Forms

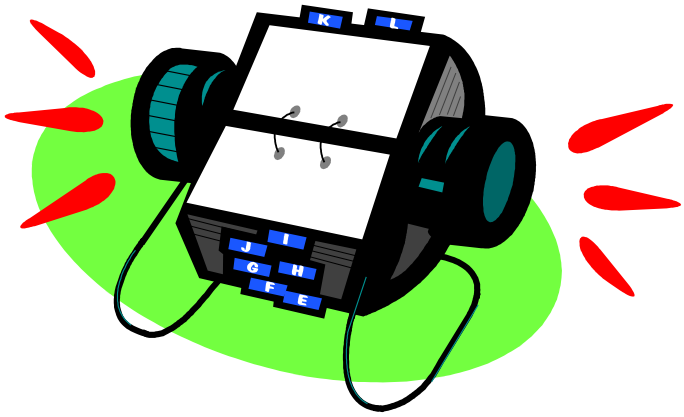
Important Information

Child's Name: _____ Nickname: _____
Address: _____
Social Security Number: _____ Date of Birth: _____
Tribal Census/Enrollment Number: _____
Medical Record Number: _____ Blood Type: _____
Allergies: _____

Parent(s)/Guardian(s)
Name(s): _____ Relationship: _____
Address: _____
Home Phone: _____ Work Phone: _____

Emergency Contact
Name: _____ Relationship: _____
Address: _____
Home Phone: _____ Work Phone: _____

Primary Care Physician
Name: _____ Name of Practice: _____
Address: _____ Phone: _____



In Case of an Emergency*

Hospital/Emergency Room Information

Hospital Name: _____

Address: _____ Phone: _____

Ambulance Services: _____ Phone: _____

Travel Directions: _____

_____

_____

_____

Medical Coverage

Primary Insurance

Policy Number: _____ Contact Person: _____

Address: _____ Phone: _____

Other Insurance

Policy Number: _____ Contact Person: _____

Address: _____ Phone: _____

Who to call in the case of a medical emergency

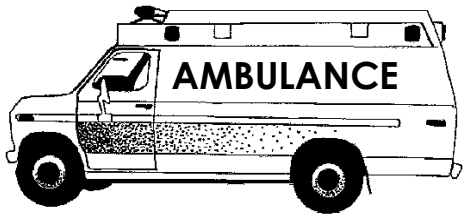
Name: _____Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____Phone: _____

***Remember to take this notebook with you to the hospital/emergency room.**



All about Me!

Information About the Child

My Name is: _____

My nickname(s) is/are: _____

I live at: □ Home □ School □ Foster Home □ Hospital

□ Other: (Please Specify) _____

Photo of Me

Favorites

Toys: _____

Animals: _____

Games: _____

Hobbies: _____

Songs: _____

TV Shows: _____

Foods: _____

Colors: _____

Movies: _____

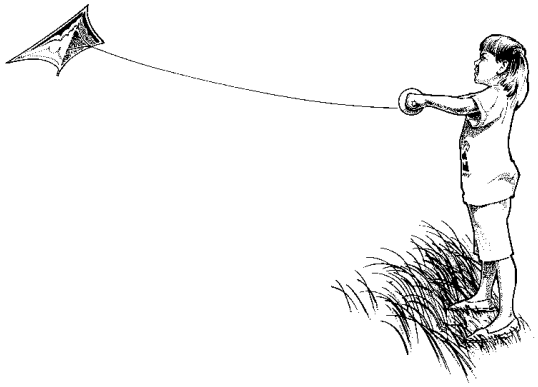
Other: _____

_____

_____

My least favorite foods are: _____

_____



More about Me...

Foods I'm allergic to: _____
Medicines I'm allergic to: _____
Other allergies: _____
_____
_____

My friends are: _____
_____
_____
_____

My pet(s) is/are: _____
Name(s) of pet(s): _____

I usually go to bed at: _____ p.m.
My bedtime routine is: _____
_____
_____

Things I need a little help with: (For example: washing up, brushing teeth, dressing, etc.): _____
_____
_____
_____

Things I can do on my own: _____
_____
_____
_____
_____

If you need to know anything else, just ask me!

Child's Birth History

Child's Name: _____ Date of Birth: _____

Method of Birth

□ Vaginal □ Cesarean □ Breach

Any complications: _____

_____

_____

_____

Mother's Ob/Gyn: _____ Phone: _____
Child's Pediatrician at Birth: _____ Phone: _____

Place of Birth
Name of Hospital: _____
Address: _____ Phone: _____
Transferring Hospital: _____
Address: _____ Phone: _____

About the Baby
Birth Weight: _____ Length: _____

Baby was: □ Full Term □ Premature_____ Months of gestation

Child's Apgar scores at one (1) minute were: ___ at five (5) minutes: _____

Child's age at first discharge from hospital: _____

About the Mother

Mother's age at onset of pregnancy: _____

Complications during the pregnancy: _____

_____

_____

_____

_____

_____

Complications during any previous pregnancies: _____

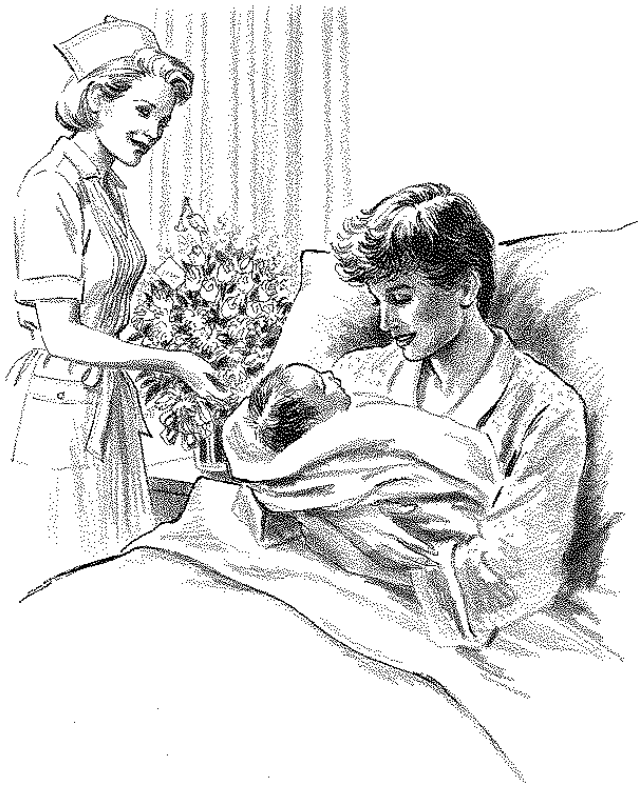
_____

_____

_____

_____

_____



Family Information

Childs Name:_____ SSN*: _____
DOB**: _____ Place of Birth: _____
Address: _____
Mothers Name: _____ SSN: _____
DOB: _____ Place of Birth: _____
Address: _____
Home Phone: _____ Work Phone: _____
Fathers Name: _____ SSN: _____
DOB: _____ Place of Birth: _____
Address: _____
Home Phone: _____ Work Phone: _____

Other Immediate Family Members

First Name:	Last Name:	Relationship:	DOB:	SSN:

Other Significant Family Members/Friends

First Name:	Last Name:	Relationship:	Phone Number:

***SSN**—Social Security Number
****DOB**—Date of Birth

Family Health History

Child's Name: _____DOB: _____

Is there anyone in the family with similar health issues/allergies/diagnoses? □ Yes □ No
If yes, whom?: _____
_____

Does anyone in the family (such as a parent, sibling, grandparent, aunt, uncle, cousin etc.) have any of the following:

			If yes, relationship to the child:
1. Cerebral Palsy	□ Yes	□ No	_____
2. Heart Problem	□ Yes	□ No	_____
3. Developmental Disability	□ Yes	□ No	_____
4. Seizure Disorder	□ Yes	□ No	_____
5. Diabetes	□ Yes	□ No	_____
6. Blood Disorder	□ Yes	□ No	_____
7. Cancer	□ Yes	□ No	_____
8. Vision/Hearing Impairment	□ Yes	□ No	_____

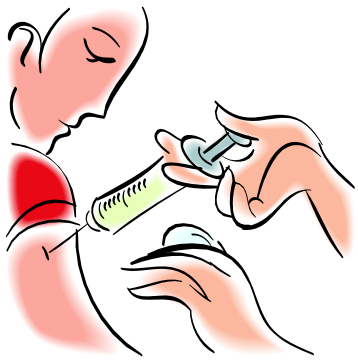
Other: _____
_____
_____

Has the family had genetic counseling? □ Yes □ No

Other information that might be helpful to know about the family's health history: _____
_____
_____
_____
_____

Immunization Records

Immunization: (Vaccine)	Date Received:	Administered by: (Name of Doctor/Nurse)	Place: (Name of Clinic)
Hepatitis B	1. 2. 3.		
DtaP (Diphtheria, Tetanus, Pertussis)	1. 2. 3.		
Td (Tetanus, Diphtheria)	1. 2. 3.		
Hib (Haemophilus Influezae B)	1. 2. 3.		
Polio	1. 2. 3.		
MMR (Measles, Mumps, Rubella)	1. 2.		
Varicella (Chickenpox)	1. 2.		
Other	1. 2. 3.		

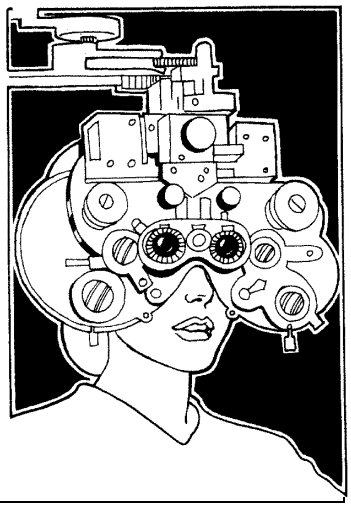


Height and Weight Records

Date:	Age:	Height:	Weight:	Blood Pressure:

Routine Healthcare Exams/Screenings

Vision



Date:	Age:	Results/Recommendations:

Hearing

Date:	Age:	Results/Recommendations:

Other Exams/Screenings

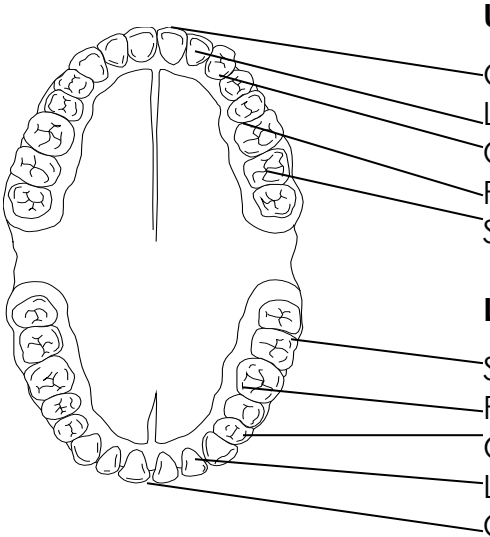
Date:	Age:	Results/Recommendations:

Record of Important Tests

Test: _____ Date Performed: _____
Description of Test: _____
Ordered by (Doctor's Name): _____
Results: _____
_____
_____
Records of the test are located at/with:
□ Doctor noted above
Address: _____ Phone: _____
□ Other: _____
Address: _____ Phone: _____
Comments: _____
_____
_____
_____

Test: _____ Date Performed: _____
Description of Test: _____
Ordered by (Doctor's Name): _____
Results: _____
_____
_____
Records of the test are located at/with:
□ Doctor noted above
Address: _____ Phone: _____
□ Other: _____
Address: _____ Phone: _____
Comments: _____
_____
_____
_____

My Child's Teeth and Dental Care



Upper Primary Teeth	Eruption	Shedding
Central Incisors	7 months	7 years
Lateral Incisors	9 months	8 years
Cuspids	18 months	11 years
First Molars	14 months	10 years
Second Molars	24 months	10 years

Lower Primary Teeth	Eruption	Shedding
Second Molars	20 months	11 years
First Molars	12 months	10 years
Cuspids	16months	9 years
Lateral Incisors	7 months	7 years
Central Incisors	6 months	6 years

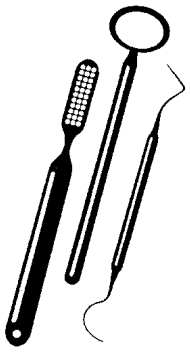
Eruption Dates of Primary Teeth

Upper	Date:	Lower	Date:
Central Incisors		Central Incisors	
Lateral Incisors		Lateral Incisors	
Cuspids		Cuspids	
First Molars		First Molars	
Secondary Molars		Secondary Molars	

Visits to the Dentist

Most dentists recommend that you take your child for his or her first visit between the ages of two (2) and three (3) years for a pleasant introduction.

Date of Visits:	Age:	Doctor's Comments/Treatments:



Childhood Illnesses

Illness:	Date:	Age:
Chickenpox		
Measles		
German Measles (Rubella)		
Mumps		
Roseola		
Whooping Cough (Pertussis)		

Common Infections
(Ear, throat, sinus, urinary, etc.)

Date:	Age:	Type of Infection/s:	Treatment/s:	Comments:

Asthma and Other Respiratory Conditions

(Bronchitis, Pneumonia, wheezing, etc.)

Date:	Age:	Type of Condition/s:	Treatment/s:	Comments:

Allergies

(Skin, food, medications, etc.)

Date:	Age:	Type of Allergies/Reactions:	Treatment/s:	Comments:

Record of Injuries, Accidents & Emergencies

Date: _____

Description of incident: _____

_____

_____

Treated by: _____

Address: _____ Phone: _____

Description of Treatment: _____

_____

Follow-up: _____

_____

Date: _____

Description of incident: _____

_____

_____

Treated by: _____

Address: _____ Phone: _____

Description of Treatment: _____

_____

Follow-up: _____

_____

Date: _____

Description of incident: _____

_____

_____

Treated by: _____

Address: _____ Phone: _____

Description of Treatment: _____

_____

Follow-up: _____

_____

Authorization for Release of Medical Records

I give permission for: (name) _____
to release: (type of information) _____
with the exception of: (type of information) _____
to: (name) _____
for the purpose of: (reason for releasing information) _____
_____
_____
This release is in regards to: (child's name) _____
Address: _____Phone: _____
Hospital/Medical Record/Clinic ID #: _____
This authorization is good until: (date) _____

Signature: _____ Date: _____

Print Name: _____ Relationship to child: _____

Milestones

How old was your child when the following actions/activities first occurred or were learned? Use this page to not only record significant dates, but to record answers to some of commonly asked questions parents have.

Activity:	Age of Child:	Questions/Comments:
Hold head up		
Rolls over back to front		
Sat unassisted		
Crawled		
First word		
First 2—3 word sentence		
Walked without holding on to anything		
Began toilet training		
Toilet Trained (Bladder)		
Toilet Trained (Bowel)		
Began feeding his/herself		
Stopped drinking from a bottle		
Other		

My Child's Primary Healthcare Providers

Primary Physician

Name: _____

Address: _____ Phone: _____

Nurses Name: _____

Dentist

Name: _____

Address: _____ Phone: _____

Pharmacy

Name: _____

Address: _____ Phone: _____

Hospital

Name: _____

Address: _____ Phone: _____

Patient ID: _____ Emergency Room #: _____

Other Healthcare Providers

Name: _____ Title: _____

Address: _____ Phone: _____

Other Providers who Care for My Child

(School, Daycare, WIC, Headstart, Early Intervention, Service Coordinator, Public Health Nurse, etc.)

Name: _____
Address: _____ Phone: _____
Services Provided: _____

Name: _____
Address: _____ Phone: _____
Services Provided: _____

Name: _____
Address: _____ Phone: _____
Services Provided: _____

Name: _____
Address: _____ Phone: _____
Services Provided: _____

Name: _____
Address: _____ Phone: _____
Services Provided: _____

Name: _____
Address: _____ Phone: _____
Services Provided: _____

Name: _____
Address: _____ Phone: _____
Services Provided: _____

Name: _____
Address: _____ Phone: _____
Services Provided: _____

Phone Log

Date/Time: _____Person Called: _____
Summary of conversation: _____
_____
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Date/Time: _____Person Called: _____
Summary of conversation: _____
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Date/Time: _____Person Called: _____
Summary of conversation: _____
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Date/Time: _____Person Called: _____
Summary of conversation: _____
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_____

Visit Notes

Before the visit

Date: _____ Doctor: _____

Reason for appointment/visit: _____

_____

_____

Medication/s child is currently taking: _____

_____

Allergies/Reactions: _____

_____

Symptoms (what they are and how long the child has had them): _____

_____

_____

Other questions/concerns: _____

_____

_____

_____

Visit Results

Outcome: _____

Medications Prescribed (names, dosage, side effects, etc.): _____

_____

Other Special Instructions (treatments, how often, how long, etc.): _____

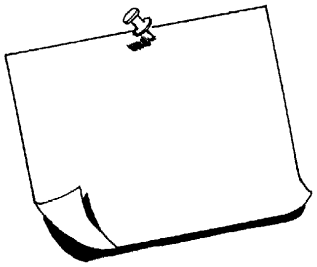
_____

_____

Follow-up/Referrals Needed: _____

_____

Date of next appointment: _____



Visit Notes

Before the visit

Date: _____ Doctor: _____

Reason for appointment/visit: _____

_____

_____

Medication/s child is currently taking: _____

_____

Allergies/Reactions: _____

_____

Symptoms (what they are and how long the child has had them): _____

_____

_____

Other questions/concerns: _____

_____

_____

_____

Visit Results

Outcome: _____

Medications Prescribed (names, dosage, side effects, etc.): _____

_____

Other Special Instructions (treatments, how often, how long, etc.): _____

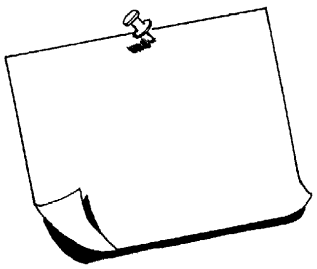
_____

_____

Follow-up/Referrals Needed: _____

_____

Date of next appointment: _____



Medication Log

(Prescription and/or over the counter)

Date:	Medication:	Dose:	How often:	Purpose:
Prescribed by:				

Date:	Medication:	Dose:	How often:	Purpose:
Prescribed by:				

Date:	Medication:	Dose:	How often:	Purpose:
Prescribed by:				

Home Health Agency

Services to be Provided
(Nursing, therapy, home health aides, etc.)

Agency Name: _____ Contact Person: _____
Address: _____ Phone: _____

Service	**Frequency (How often per week)**	**Amount (Hours per week)**
	Visits per week	Hours per visit
	Visits per week	Hours per visit
	Visits per week	Hours per visit
	Visits per week	Hours per visit
	Visits per week	Hours per visit

Agency Name: _____ Contact Person: _____
Address: _____ Phone: _____

Service	**Frequency (How often per week)**	**Amount (Hours per week)**
	Visits per week	Hours per visit
	Visits per week	Hours per visit
	Visits per week	Hours per visit
	Visits per week	Hours per visit
	Visits per week	Hours per visit

Supplies & Equipment

Description of item: ______________________________
Provider/Vendor Name: ______________________________
Contact Person: ______________________ Phone: __________
Prescribed by: ______________________ Phone: __________
Reason Prescribed: ______________________________
____
Service Contact Person: ______________________ Phone: __________
Comments: ______________________________
____
____

Description of item: ______________________________
Provider/Vendor Name: ______________________________
Contact Person: ______________________ Phone: __________
Prescribed by: ______________________ Phone: __________
Reason Prescribed: ______________________________
____
Service Contact Person: ______________________ Phone: __________
Comments: ______________________________
____
____

Description of item: ______________________________
Provider/Vendor Name: ______________________________
Contact Person: ______________________ Phone: __________
Prescribed by: ______________________ Phone: __________
Reason Prescribed: ______________________________
____
Service Contact Person: ______________________ Phone: __________
Comments: ______________________________
____
____

Phone Log

Date/Time: _____Person Called: _____
Summary of conversation: _____
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Summary of conversation: _____
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Date/Time: _____Person Called: _____
Summary of conversation: _____
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Date/Time: _____Person Called: _____
Summary of conversation: _____
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_____

School Information

Date: _____ School Year: _____
Name of School: _____
Address: _____ Phone: _____
School Identification Number: _____
Principal _____ Phone: _____
Assistant Principal: _____ Phone: _____
Nurse: _____ Phone: _____
Social Worker: _____ Phone: _____
Cafeteria: _____ Phone: _____
Other: _____ Phone: _____
Other: _____ Phone: _____

Teacher: _____ Room #: _____ Phone: _____
Teacher: _____ Room #: _____ Phone: _____
Teacher: _____ Room #: _____ Phone: _____
Teacher: _____ Room #: _____ Phone: _____
Teacher: _____ Room #: _____ Phone: _____
Teacher: _____ Room #: _____ Phone: _____
Teacher: _____ Room #: _____ Phone: _____

Bus Driver's Name: _____ Bus #: _____ Phone: _____
Bus Driver's Name: _____ Bus #: _____ Phone: _____

After School Programs
(Leisure & Recreational)

Activity: ______________________________ Agency: ____________
Address: ______________________________ Phone: ____________
Contact Person: ________________________ Hours: ____________

Activity: ______________________________ Agency: ____________
Address: ______________________________ Phone: ____________
Contact Person: ________________________ Hours: ____________

Activity: ______________________________ Agency: ____________
Address: ______________________________ Phone: ____________
Contact Person: ________________________ Hours: ____________

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Address: ______________________________ Phone: ____________
Contact Person: ________________________ Hours: ____________

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Address: ______________________________ Phone: ____________
Contact Person: ________________________ Hours: ____________

Activity: ______________________________ Agency: ____________
Address: ______________________________ Phone: ____________
Contact Person: ________________________ Hours: ____________

Activity: ______________________________ Agency: ____________
Address: ______________________________ Phone: ____________
Contact Person: ________________________ Hours: ____________

Other after School Services

(Occupational therapy, physical therapy, speech, etc.)

Service: _____ Provider: _____
Address: _____ Phone: _____
Therapy days: _____ Times: _____

Service: _____ Provider: _____
Address: _____ Phone: _____
Therapy days: _____ Times: _____

Service: _____ Provider: _____
Address: _____ Phone: _____
Therapy days: _____ Times: _____

Service: _____ Provider: _____
Address: _____ Phone: _____
Therapy days: _____ Times: _____

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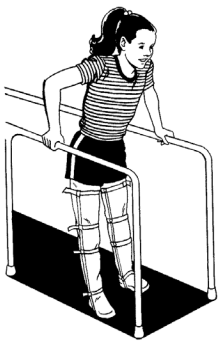
Address: _____ Phone: _____
Therapy days: _____ Times: _____



Phone Log

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Date/Time: _____Person Called: _____
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Date/Time: _____Person Called: _____
Summary of conversation: _____
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_____
_____
_____

Date/Time: _____Person Called: _____
Summary of conversation: _____
_____
_____
_____
_____
_____

Important Information for Your Child's Sitter

(Keep this form readily available for your child's sitter in case of an emergency.)

Emergency Medical Service (EMS) Phone: _____

Child's Name: _____ Date of Birth: _____

Address: _____

Directions to house: _____

_____

_____

Primary Care Physician: _____ Phone: _____

Significant events during the past 48 hours: _____

_____

_____

Medication(s) to be given and time(s): _____

_____

_____

Allergies: _____

Extra equipment/supplies are located: _____

_____

Fuse box or breaker is located: _____

_____

Flashlight is located: _____

We will be at: _____

The telephone number is: _____

We will be home around: _____

Special Instructions: _____

_____

_____

_____

Resource Contact Sheets

Problem/Topic: _____

Name of agency contacted: _____

Name of contact person, or person you spoke with:

Date you called: _____ Phone: _____

Results of discussion: _____

_____

_____

_____

_____

_____

Action taken (if any): _____

_____

_____

_____

_____

Was this person helpful on this topic?

□ Yes □ No

If no, list other topics, areas, issues, etc. in which you feel this person or agency may be helpful in the future: _____

_____

_____

_____

_____

_____

Phone Directory

Name :	Address:	Phone: