Health Care Notebook

This notebook is for:

Compiled by the Parent to Parent of NYS
Family to Family Health Care
Information and Education Center
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Section 1: Introduction
A Parent and Child’s Health Care Notebook

The goal of a Health Care Notebook is to provide a central location for important information regarding your child’s special health care needs. Record keeping is a must when parenting a child with special health care needs. Parent to Parent of NYS has created this notebook to provide an invaluable reference tool that will make keeping your child’s records easy and convenient. Imagine being able to find information at a moment’s notice? Well, you can with this notebook. We are parents of children with special needs and understand the need for locating information at a moment’s notice!

The Health Care Notebook has value that far exceeds simple organization. It is a crucial tool to help in developing a partnership with the professionals who provide care to your child. As you become more organized you will develop the skill of when and then. You will approach your health care professionals thinking, “When this happens then I will....”

You might realize that you need more of a particular page. The pages are on the Parent to Parent of NYS website available for downloading. For anyone without access to the Internet, our offices can mail or fax the pages you need.

There are various Health Care Notebooks in use and available on the Internet. No single book will completely address every child’s needs. We have included a listing other notebooks in the references section, which can be downloaded and combined with any of the Parent to Parent of NYS pages to add to your notebook, creating a personalized notebook that works for you.
Quick Tips Before Getting Started

What is a Health Care Notebook?

A Health Care Notebook is an organizational tool for families who have children with special health care needs. Using a Health Care Notebook can help you keep track of important information about your child’s health, providers and health history.

How can this help me?

In caring for your child with special health care needs you will receive information from many sources. This Health Care Notebook will help you organize information in one central place. It will help you track changes in medication and or treatments and it provides a place where you can refer back to health care professionals who have provided past services (i.e. speech therapist from Pre-K, first ENT, etc.). It is a place to keep phone numbers, doctors, locations of testing, vendors of durable medical equipment, serial numbers, authorizations/approvals, etc., in one place.

The process of organizing the records will improve your ability to effectively partner with your child’s health care providers in the decision-making process. Additionally, the Health Care Notebook can be used as a tool to support the development of health care related skills for the child who is transitioning to adulthood.

What are some helpful hints for using my child’s health care notebook?

- Keep this notebook where it is accessible (not in a closet or in the attic).

- Add new information daily, monthly, weekly or after medical appointments or phone calls regarding your child’s health care.

- It may be beneficial to bring the Health Care Notebook to medical appointments.

- The more this notebook is updated, the more valuable it will become to you and to your child.
Section 2

Emergency Medical Contact Information Form
Directions to Your House
Family Directory
Family Medical History
Emergency Contact and Medical Information for a Child

Child’s Name ________________________________________________________________________

Date of Birth ___________________________________________________________ Sex □ M □ F

Parent’s/Guardian’s Name ____________________________ Parent’s/Guardian’s Name ____________________________

Home Phone (______) ___________________ Home Phone (______) ___________________

Work Phone (______) ____________________ Work Phone (______) ____________________

Address ____________________________________________ ____________________________________________

City ST ZIP Code City ST ZIP Code

Alternative Emergency Contacts

Primary Emergency Contact ____________________________ Secondary Emergency Contact ____________________________

Home Phone (______) ___________________ Home Phone (______) ___________________

Work Phone (______) ____________________ Work Phone (______) ____________________

Address ____________________________________________ ____________________________________________

City ST ZIP Code City ST ZIP Code

Medical Information

Hospital/Clinic Preference _____________________________________________________________

Physician’s Name ____________________________ Phone Number (______)_____________

Insurance Company ____________________________ Policy Number (______)_____________

Allergies/Special Health Considerations _________________________________________________

__________________________________________________________________________________

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

Parent’s/Guardian’s Signature ____________________________ Date __________

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Directions to Your House

(This information will be available in the event you panic or freeze and forget your address when calling 911 or, to leave for a babysitter, nurse or relative watching your child at your house.)

________________________________________________________________________

STREET ADDRESS

________________________________________________________________________

CROSS STREETS

________________________________________________________________________

PHONE NUMBER

________________________________________________________________________

DIRECTIONS: ____________________________________________________________

________________________________________________________________________

________________________________________________________________________

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Family Directory

Parent(s) or Guardian(s)

Name _____________________________  Relationship _____________________________
Address _______________________________________________________________________
City _____________________________  State _______  Zip Code ______________________
Phone: Home (______) _____________  Cell (______) ______________  Work (______) ______________

Name _____________________________  Relationship _____________________________
Address _______________________________________________________________________
City _____________________________  State _______  Zip Code ______________________
Phone: Home (______) _____________  Cell (______) ______________  Work (______) ______________

Other Non-Sibling Relatives

Name _____________________________  Relationship _____________________________
Address _______________________________________________________________________
City _____________________________  State _______  Zip Code ______________________
Phone: Home (______) _____________  Cell (______) ______________  Work (______) ______________

Name _____________________________  Relationship _____________________________
Address _______________________________________________________________________
City _____________________________  State _______  Zip Code ______________________
Phone: Home (______) _____________  Cell (______) ______________  Work (______) ______________

Name _____________________________  Relationship _____________________________
Address _______________________________________________________________________
City _____________________________  State _______  Zip Code ______________________
Phone: Home (______) _____________  Cell (______) ______________  Work (______) ______________
Family Directory (continued)

**Siblings**

Name _______________________________ DOB___________ Gender: □ M □ F
Address ___________________________________________________________________________
Phone: Home (____) _____________ Cell (____) _____________ Work (____) _______________

Name _______________________________ DOB___________ Gender: □ M □ F
Address ___________________________________________________________________________
Phone: Home (____) _____________ Cell (____) _____________ Work (____) _______________

Name _______________________________ DOB___________ Gender: □ M □ F
Address ___________________________________________________________________________
Phone: Home (____) _____________ Cell (____) _____________ Work (____) _______________

Name _______________________________ DOB___________ Gender: □ M □ F
Address ___________________________________________________________________________
Phone: Home (____) _____________ Cell (____) _____________ Work (____) _______________
Family Medical History Form

Child’s Name: First _________________________ M.I. _______ Last __________________________

Date of Birth ______/______/_________ Gender □ M □ F Ethnicity ______________________

Current Physician(s):  Name _____________________________ Phone (______)_________________

                                   Name _____________________________ Phone (______)_________________

Please list the current status of your child’s immediate family:

<table>
<thead>
<tr>
<th>Grandparents Name(s)</th>
<th>Living/Deceased</th>
<th>Age (Now or at Death)</th>
<th>Comments or Cause of death</th>
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</thead>
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</table>

<table>
<thead>
<tr>
<th>Parents Name(s)</th>
<th>Living/Deceased</th>
<th>Age (Now or at Death)</th>
<th>Comments or Cause of death</th>
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</table>

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<thead>
<tr>
<th>Siblings Name(s)</th>
<th>Living/Deceased</th>
<th>Age (Now or at Death)</th>
<th>Comments or Cause of death</th>
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</tbody>
</table>
Family Medical History Form (continued)

Please indicate all known health conditions that apply to your child and members of their immediate family, including parents, grandparents and siblings, below:

<table>
<thead>
<tr>
<th>Health Condition</th>
<th>Me</th>
<th>Age of onset/type</th>
<th>Family Member(s)</th>
<th>Age of onset/type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s</td>
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<tr>
<td>Arthritis</td>
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<tr>
<td>Asthma/Allergies</td>
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<tr>
<td>Aneurysm</td>
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<tr>
<td>Blood Clots</td>
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<tr>
<td>Blood Disorders</td>
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<tr>
<td>Cancer:</td>
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<tr>
<td>Breast</td>
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<td>Colon</td>
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<tr>
<td>Prostate</td>
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<tr>
<td>Lung</td>
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<tr>
<td>Other</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Epilepsy/Seizures</td>
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<tr>
<td>Eye Condition</td>
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<tr>
<td>Heart Disease</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>High Cholesterol</td>
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<tr>
<td>Kidney Disease</td>
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<tr>
<td>Lung Disease</td>
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<tr>
<td>Osteoporosis</td>
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<tr>
<td>Mental Disorders</td>
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<tr>
<td>Smoking</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Thyroid Disorders</td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>
Section 3

Child’s Medical History
Allergies
Growth Tracking Form
Dental Information
Vision Information
Medication Log
Hospitalizations, Surgeries, Medical Procedures
Lab Work, Diagnostic Tests
Activities of Daily Living
Daily Treatments
Durable Medical Equipment (DME)
Child’s Medical History

Child’s Name: First _________________________ M.I. _______ Last __________________________
Nickname ____________ _______ Date of Birth ______/_____/_________ Gender □ M □ F
Child’s Social Security: __________ - _____ - _______________
Address ____________________________________________________________________________
City ______________________________ State __________ Zip Code ____________

## Diagnosis

<table>
<thead>
<tr>
<th>Date</th>
<th>Physician</th>
<th>Diagnosis</th>
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</table>

## Immunization Record

Enter the date the following immunizations are received in the boxes.

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Date</th>
<th>Physician</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hep B</td>
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<tr>
<td>DtaP/Tdap</td>
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<tr>
<td>Hib</td>
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<tr>
<td>Polio</td>
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<td>PCV</td>
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<td>MMR</td>
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<tr>
<td>Varicella</td>
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<tr>
<td>Hep A</td>
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<tr>
<td>MCV4</td>
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<tr>
<td>TB Status</td>
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<td>Other</td>
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<td>Other</td>
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<td>Other</td>
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</tbody>
</table>
Allergies
(Medication, Food, Insects)

Allergy ____________________________
Type of Reaction ____________________________
Signs & Symptoms ____________________________
Management (including antidote with dosage) ____________________________

Allergy ____________________________
Type of Reaction ____________________________
Signs & Symptoms ____________________________
Management (including antidote with dosage) ____________________________

Allergy ____________________________
Type of Reaction ____________________________
Signs & Symptoms ____________________________
Management (including antidote with dosage) ____________________________

Allergy ____________________________
Type of Reaction ____________________________
Signs & Symptoms ____________________________
Management (including antidote with dosage) ____________________________
# Growth Tracking Form

<table>
<thead>
<tr>
<th>Age</th>
<th>Height</th>
<th>Weight</th>
<th>Checked By</th>
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</table>
# Dental Information

## Dentist

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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Phone (______) __________ Fax (______) ______________ Contact Person ______________

Show location of crowns, bridges or other major dental work done. Mark the diagram and give a brief description.

<table>
<thead>
<tr>
<th>Description</th>
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## Orthodontist or Oral Surgeon

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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</table>

Phone (______) __________ Fax (______) ______________ Contact Person ______________

Braces □ Yes □ No Appliance Worn ______________

Instructions ___________________________________ _______________________________________

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Vision Information

Ophthalmologist/ Optometrist

Name _____________________________________________________________

Address _________________________________________________________

City __________________ State _______ Zip Code ______________________

Phone (____) ___________ Fax (____) ___________ Contact Person __________

Current Prescription _____________________________________________

Contact Lenses Type _____________________________________________

Daily Wear and Care Instructions: ___________________________________

Date of Last Exam ______/_____/___________ Any Changes _______________________

Eyes Injuries _____________________________________ Date ______________

________________________________________________ Date ______________

Optical Store Name ______________________________________________

Address: _________________________________________________________

Phone (____) ___________ Contact Person ______________________________
# Medication Log

(Including supplies that don’t require an Rx)

<table>
<thead>
<tr>
<th>Medication (with Concentration)</th>
<th>Physician</th>
<th>RX #</th>
<th>Reason</th>
<th>Dosage &amp; Route</th>
<th>Time Administered</th>
<th>Date Ordered</th>
<th>Date Discontinued</th>
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</table>
## Hospitalizations, Surgeries & Procedures

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure</th>
<th>Admitting Physician</th>
<th>Surgeon</th>
<th>Hospital / Facility</th>
<th>Address</th>
<th>Phone Number (______)</th>
<th>Date Discharged</th>
<th>Instructions</th>
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</tbody>
</table>
# Lab Work & Diagnostic Tests

<table>
<thead>
<tr>
<th>Date</th>
<th>Physician</th>
<th>Test Results</th>
<th>Comments</th>
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</thead>
<tbody>
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Activities of Daily Living

Use this page to talk about your child’s abilities to care for himself/herself or the specific needs they have. Reference additional sheets if necessary.

Nutrition
___________________________________________________________________________
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Respiratory
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Communication
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Mobility
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Sleep
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Social/Play
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___________________________________________________________________________

Coping/Stress
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Toileting & Personal Hygiene
___________________________________________________________________________
___________________________________________________________________________
Daily Treatments

This page is designed to be an overview of daily care activities in the event parents are called away suddenly and a relative, nurse or aide is filling in. The idea behind this page is for parents to keep an updated daily schedule on file. You may consider creating a personalized regimen for each of these areas as applicable and filing your notes behind this page in the notebook.

Vital Signs

Respiratory

Trach

G-Tube

Bowel/Bladder Regimen

Adaptive Equipment
Durable Medical Equipment ("DME") Or Supplies (Including glasses, hearing aides, & items that requires Rx)

Equipment or Supply ________________________________________________________________
Vendor ____________________________________________________________________________
Contact Person ______________________________________________________________________
Address ______________________________________________________________________________
Phone Number (_______)_________________
Serial Number ______________ Date Obtained _____________________
Repairs ______________________________________________________________________________
Authorization No. _____________________________________________________________________
Current Settings / Dosage _____________________________________________________________

Equipment or Supply ________________________________________________________________
Vendor ____________________________________________________________________________
Contact Person ______________________________________________________________________
Address ______________________________________________________________________________
Phone Number (_______)_________________
Serial Number ______________ Date Obtained _____________________
Repairs ______________________________________________________________________________
Authorization No. _____________________________________________________________________
Current Settings / Dosage _____________________________________________________________
Section 4

Checklist of Specialty Physicians

Health Care Providers Directory

School Information

Family Support & Local Resources

Contacts Log
Specialty Physicians Check List

Check the box next to specialists included in your child’s care.

☐ Anesthesiologists
☐ Dermatologists
☐ Endocrinologists
☐ Family Medicine
☐ Gastroenterologists
☐ Gynecologists
☐ Immunologists
☐ Internists
☐ Nutritionists
☐ Social Workers
☐ Other __________________________
☐ Other __________________________
☐ Other __________________________

☐ Neurosurgeons
☐ Oncologists
☐ Neurologists
☐ Ophthalmologists
☐ Orthopedists
☐ Otolaryngologists
☐ Pediatricians
☐ Podiatrists
☐ Psychiatrists
☐ Radiologists
☐ Urologists
☐ Other __________________________
☐ Other __________________________
Health Care Provider Directory

Primary Care Provider/Physician (PCP)

Name

Address

City ______________ State __________ Zip Code ______________________

Phone (______) ___________ Fax (______) ______________ Emergency No. (______) ____________

Hospital(s) affiliated with ________________________________________________

Name of office personnel that were helpful __________________________________

Primary Care Provider/Physician (PCP)

Name

Address

City ______________ State __________ Zip Code ______________________

Phone (______) ___________ Fax (______) ______________ Emergency No. (______) ____________

Hospital(s) affiliated with ________________________________________________

Name of office personnel that were helpful __________________________________
# Health Care Provider Directory, continued

## Specialists

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<th>Specialty</th>
<th>Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<th>Emergency No.</th>
<th>Hospital(s) affiliated with</th>
<th>Name of office personnel that were helpful</th>
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© 2010 Parent to Parent of NYS Family to Family Health Care Information and Education Center

NAME:
Home Care Agency

**Agency**

__________________________

**Address**

__________________________

City __________________ State _______ Zip Code __________________

Phone (______) ___________ Fax (______) ______________ Emergency No. (______) ___________

Contact Person ____________________________________________

Pharmacies

**Local Pharmacy**

__________________________

**Address**

__________________________

City __________________ State _______ Zip Code __________________

Phone (______) ___________ Fax (______) ______________

Contact Person ____________________________________________

**Mail Order Pharmacy**

__________________________

**Address**

__________________________

City __________________ State _______ Zip Code __________________

Phone (______) ___________ Fax (______) ______________

Contact Person ____________________________________________

**Specialty Pharmacy (Compounding, Intravenous Medications, etc)**

**Name**

__________________________

**Address**

__________________________

City __________________ State _______ Zip Code __________________

Phone (______) ___________ Fax (______) ______________

Contact Person ____________________________________________
Therapists

**Speech Therapist**
School/Agency ____________________________
Phone (____) ______________ Fax (____) ______________
Email Address ____________________________

**Physical Therapist**
School/Agency ____________________________
Phone (____) ______________ Fax (____) ______________
Email Address ____________________________

**Occupational Therapist**
School/Agency ____________________________
Phone (____) ______________ Fax (____) ______________
Email Address ____________________________

**Respiratory Therapist**
School/Agency ____________________________
Phone (____) ______________ Fax (____) ______________
Email Address ____________________________

**Other**
School/Agency ____________________________
Phone (____) ______________ Fax (____) ______________
Email Address ____________________________
School Information

School ____________________________________________________________
Address __________________________________________________________
City __________________________ State ___________ Zip Code __________________________
Phone (_____) _____________ Fax (_____) ______________

Key School Personnel

Principal __________________________________________________________
Phone (_____) _____________ Ext. _______ Email Address _____________________________

Principal’s Secretary _____________________________________________
Phone (_____) _____________ Ext. _______ Email Address _____________________________

Current Teacher _________________________________________________
Phone (_____) _____________ Ext. _______ Email Address _____________________________

School Nurse ____________________________________________________
Phone (_____) _____________ Ext. _______ Email Address _____________________________

School Psychologist ______________________________________________
Phone (_____) _____________ Ext. _______ Email Address _____________________________

Chairperson of CSE ______________________________________________
Phone (_____) _____________ Ext. _______ Email Address _____________________________

Transportation / Bus # _____________________________________________
Phone (_____) _____________ Ext. _______ Email Address _____________________________
Family Support Information

Service Coordination/Case Management

Agency Name ____________________________________________

Service Coordinator/Case Manager’s Name ____________________________

Address _________________________________________________________________________

City ___________________________ State ___________ Zip Code ______________________

Phone (______) _____________ Fax (______) __________________

Email Address _______________________________________

Respite Services

Name ____________________________

Address _________________________________________________________________________

City ___________________________ State ___________ Zip Code ______________________

Phone (______) _____________ Fax (______) __________________

Email Address ________________________________________ Contact Person _________________

Parent to Parent of NYS

Regional Office ____________________________________________

Address _________________________________________________________________________

City ___________________________ State ___________ Zip Code ______________________

Phone (______) _____________ Fax (______) __________________

Email Address ________________________________________ Contact Person _________________

Website: www.parenttoparentnys.org

Support Group

Address _________________________________________________________________________

City ___________________________ State ___________ Zip Code ______________________

Phone (______) _____________ Fax (______) __________________

Email Address ________________________________________ Contact Person _________________
Family Support Information, continued

Child’s Diagnosis Foundation

Agency Name__________________________________________________________
Address _____________________________________________________________________________________________
City ___________________________ State ___________ Zip Code ________________________________
Phone (______) ____________________  Fax (______) ______________________
Email Address ________________________________  Contact Person ___________________________

Advocacy Group

Agency Name__________________________________________________________
Address _____________________________________________________________________________________________
City ___________________________ State ___________ Zip Code ________________________________
Phone (______) ____________________  Fax (______) ______________________
Email Address ________________________________  Contact Person ___________________________

Religious/Church Affiliation

Agency Name__________________________________________________________
Address _____________________________________________________________________________________________
City ___________________________ State ___________ Zip Code ________________________________
Phone (______) ____________________  Fax (______) ______________________
Email Address ________________________________  Contact Person ___________________________
# Contacts Log

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Section 5

Health Insurance
Financial Support
Out-of Pocket Expenses
Health Insurance

**Primary Insurance Carrier**

Name of Plan

Subscriber (Name of Policy Holder)

Address

City       State       Zip Code

Phone (____)       Fax (____)

ID#       Group #

**Case Manager/Care Coordinator/Case Worker**

Name:

Phone (____)       Fax (____)

E-Mail Address

**Secondary Insurance Carrier**

Name of Plan

Subscriber (Name of Policy Holder)

Address

City       State       Zip Code

Phone (____)       Fax (____)

ID#       Group #

**Case Manager/Care Coordinator/Case Worker**

Name:

Phone (____)       Fax (____)

E-Mail Address
Financial Support

SSI – Supplemental Security Income

Contact Person __________________________________________________________

Phone Number (_____)_________________ Email ________________________________

Address ___________________________________________________________________

Website ___________________________________________________________________

Medicaid

Contact Person __________________________________________________________

Phone Number (_____)_________________ Email ________________________________

Address ___________________________________________________________________

Website ___________________________________________________________________

Care At Home/HCBS Waiver

Contact Person __________________________________________________________

Phone Number (_____)_________________ Email ________________________________

Address ___________________________________________________________________

Website ___________________________________________________________________

Physically Handicapped Children’s Program (“PHCP”) 

Contact Person __________________________________________________________

Phone Number (_____)_________________ Email ________________________________

Address ___________________________________________________________________

Website ___________________________________________________________________
Out-Of-Pocket Expenses

There may be opportunities for reimbursement through a Flex Plan or a medical deduction on income tax returns. Documentation of Out-of-Pocket Expenses might be needed to meet a Spend Down requirement. If records are kept throughout the year (i.e. mileage, parking, over the counter medications, medical supplies, etc.), the information will be readily available when needed. Consider adding a pocket folder behind this page to store receipts.

<table>
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<th>Item / RX</th>
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Section 6

Additional Health Care Notebook Links

About Parent to Parent of NYS

Parent to Parent of NYS Offices
Links to Other Health Care Notebooks

- *Utah, includes a Spanish version*

http://www.health.state.ri.us/family/disability/cc-notebook.php
- *Rhode Island*

http://cshcn.org/planning-record-keeping/care-notebook
- *Seattle Children’s Hospital*

http://www.medicalhomeinfo.org/tools/CarePlans/CHMCC%20notebook.doc
- *Ohio*

http://www.ccids.umaine.edu/archive/maineworks/carenotebook.htm
- *Maine*

http://www.medicalhomeinfo.org/Tools/care_notebook.html
- *American Academy of Pediatrics*

Links to Other Health and Safety Info

*Emergency Contact Sheet*
http://kidshealth.org/parent/firstaid_safe/sheets/emergency_contact.html?tracking=P_RelatedArticle

*When Your Child Needs Emergency Medical Services*
http://www.aap.org/family/frk/EMSFRK.pdf

*Power of the Parents, A Safety & Awareness Program*
http://www.powerofparentsonline.com/

*New York State Institute for Health Transition Training*
www.healthytransitionsny.org
Parent to Parent of NYS Overview

Parent to Parent of NYS is a statewide not for profit organization with a mission to support and connect families of individuals with special needs. We are a point of contact for many parents who are ‘getting started’ on their journey of parenting a child with developmental disabilities. There are 14 offices throughout NYS, staffed by Regional Coordinators, who are parents or close relatives of individuals with special needs. A website is maintained to provide information and events listings - www.parenttoparentnys.org

A Support Parent Network of over 1200 parents is the backbone of the Parent Matching Program. It has been created and is maintained by Parent to Parent Regional Coordinators. This is a model program used across the country to put parents in touch on a one to one basis with other parents who have a child with a chronic illness or disability. “Support Parents” are parents of individuals with special needs who have made the offer to speak one to one with “new” parents and share their experiences. Support parents are the key to this program. The organization recognizes the need for emotional support as well as the importance of parents knowing they are not alone.

When parents agree to be Support Parents, they are provided a skills building training, which includes an overview of how the program works, an understanding of the stages and emotions a parent or caregiver may be experiencing, as well as listening skills. New parents are welcome to join the Support Parent network and to share their experience.

In addition to the Parent Matching program, the organization fields telephone calls from parents of children with special needs who are looking for resources, services and information. Calls include parents looking for information about medical services and therapies and those looking for information specifically about an illness or disability. There are often questions about special education. All programs are based on the philosophy of parents helping each other, drawing on a network of parents helping parents. Coordinators are there to assist, but draw on other parents to help. There is no charge for services.

The Family to Family Health Care Information Center assists families with access to health care, health care recordkeeping and transition from pediatric to adult health care. Information about this program can be viewed at the website.
Contact Parent to Parent of New York State...

**ADIRONDACK**
Clinton, Essex, Franklin & Hamilton Counties
P.O. Box 1296
Tupper Lake, NY 12986
1-866-727-6970, 518-359-3006
Fax 518-359-2151

**CAPITAL REGION**
Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren & Washington Counties
500 Balltown Road
Schenectady, NY 12304
1-800-305-8817, 518-381-4350
Fax 518-393-9607

**FINGER LAKES**
Livingston, Monroe, Ontario, Yates & Wayne Counties
The Advocacy Center
590 South Avenue
Averill Court
Rochester, NY 14620
1-800-650-4967, 585-546-1700 ext. 242; Fax 585-223-2481

**HUDSON VALLEY**
Orange, Rockland, Sullivan and Westchester Counties
WHBD / Cedarwood Hall
Valhalla, NY 10595
1-800-305-8816, 914-493-2635
Fax 914-493-8066

**LONG ISLAND**
Nassau and Suffolk Counties
415-A Oser Ave.
Hauppauge, NY 11788
1-800-559-1729, 631-434-6196
Fax 631-434-6151

**NORTH CENTRAL NY—SYRACUSE**
Cayuga, Cortland, Herkimer, Lewis, Madison, Oneida, Onondaga and Oswego Counties
Exceptional Family Resources
1820 Lemoyn Ave
Syracuse, NY 13208
1-800-305-8815, 315-478-1462, x 322
Fax 315-478-1467

**SEAWAY VALLEY**
St. Lawrence & Jefferson Counties
PO Box 753
Canton, NY 13617
1-800-603-6778, 315-379-1538
(fax is the same)

**SOUTHERN TIER**
Chemung, Schuyler, Steuben & Seneca Counties
P.O. Box 205, 210-12th St. #210
Watkins Glen, NY 14891
1-800-971-1588, 607-535-2802
(fax is the same)

**TACONIC**
Columbia, Dutchess, Greene, Putnam and Ulster Counties
26 Center Circle,
Bldg. 59, Rm. B46
Wassaic, NY 12592
1-877-725-4322
845-877-0654
(fax is the same)

**WESTERN NY**
Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans & Wyoming Counties
1200 East & West Road
Building 16, Room 1-131
West Seneca, New York 14224
1-800-305-8813, 716-517-3448
Fax 716-517-2385

**NEW YORK CITY**
Serving the Five Boroughs
75 Morton Street
New York, NY 10014
1-800-405-8818, 212-229-3188 or
212-741-5545, Fax 212-229-3146

**STATEN ISLAND**
c/o IBR, 1050 Forest Hill Road, #108
Staten Island, NY 10314
1-800-866-1068, 718-494-3462
Fax 718-494-0319

**BUSINESS OFFICE**
P.O. Box 1296
Tupper Lake, NY 12986
1-866-727-6970, 518-359-3006
Fax 518-359-2151