

My Childs Baseline



DOB _____

First name _____

PHN: _____

Last Name _____

BASELINE OVERVIEW

Primary diagnosis: _____

Seizure type(s): _____

Usual level of alertness: _____

Feeding method: _____

Respiratory support (if any): _____

Note:

THIS IS DIFFERENT FOR MY CHILD

Normal breathing looks like: _____

Work of breathing (normal for my child): _____

eg: "Frequent gagging is typical"

CONTACTS

Parent/Guardian(s):

Backup Contact:

Primary Medical Team:

Note:

FEEDING & GI



FEEDING BASELINE

Feeding method:

Feeding tolerance:

Usual intake:

ASSOCIATED CHANGES

Baseline vomiting/retching (if any):

What is typical vs concerning:

VITALS



SLEEP PATTERNS

Typical sleep schedule: _____

Night-time concerns: _____

What is normal for my child: _____

Note:

HEART RATE / TEMPERATURE

Typical heart rate range: _____

Typical temperature baseline: _____

Note:

MONITORING AT HOME

Devices used: _____

What readings are normal for my child: _____

Note:

IMPORTANT



CONTACTS

Parent/Guardian(s):

Backup Contact:

Primary Medical Team:

WHEN THIS IS NOT BASELINE

- Breathing that is different from usual
- Oxygen outside typical range for this child
- Seizures that are longer, stronger, or different
- Changes in alertness or responsiveness
- Feeding intolerance beyond normal pattern
- Anything that feels different from baseline
