About My Child - *Caregiver & Medical Reference*

DOB _____ First name _____

PHN: _____ Last Name _____

QUICK OVERVIEW

Diagnosis: _____

Seizure Type(s): _____

Medical Complexity Notes: _____

Devices / Supports (if any): _____

Note:

COMMUNICATION

My child communicates by: _____

Signs of discomfort: _____

Signs of distress: _____

Signs of pain: _____

Note:

WHAT HELPS MY CHILD FEEL SAFE

Comfort strategies: _____

Sensory preferences (light, sound, touch):_____

What calms my child: _____

Note:

Note:

WHAT CAUSES DISTRESS

Triggers or sensitivities: _____

Things to avoid: _____

Note:

BASELINE BEHAVIOR

Normal alertness: _____

Normal movement/tone: _____

What is typical for my child: _____

Be aware of:

MOBILITY

Mobility level: _____

Assistance required: _____

Note:

Note:

POSITIONING NEEDS

Preferred positioning: _____

Important positioning notes: _____

Note

ADDITIONAL CONSIDERATIONS

Allergies: _____

Equipment used: _____

Monitoring at home: _____

Other important medical information: _____

Be aware of:

PLEASE KNOW THIS ABOUT MY CHILD

IMPORTANT MEDICATION NOTES

MEDICATION ROUTINE

FEEDING METHOD AND NOTES

FEEDING ROUTINE

NIGHT-TIME CONCERNS

SLEEP ROUTINE & PATTERN

EMERGENCY CONTACTS

PRIMARY CONTACTS

This tool is intended to support caregiver communication and preparedness. It does not replace medical advice, diagnosis, or emergency care. Follow guidance from your child's medical team.