Section 5 Contact Information

Communication with all of the people involved in your child's care and well-being is critically important. Having the information to contact them in one accessible place is helpful, especially during times of crisis. Use this section to create a personalized directory of your child's team. You may want to insert plastic pages for business cards, or even tape business cards to the pages themselves.

Insert Picture, Business Cards, Etc. here

Medical/Dental Healthcare Providers

Primary Care Provider: _____

Date of First Visit: _____

Office Nurse/Medical Assistant: _____

Address: _____

Phone: _____ Fax: _____ E-Mail: _____

Community Hospital: _____

Address: _____

Phone: _____ Fax: _____ E-Mail: _____

Dental Provider: _____

Date of First Visit: _____

Address: _____

Phone: _____ Fax: _____ E-Mail: _____

Orthodontist: _____

Date of First Visit: _____

Address: _____

Phone: _____ Fax: _____ E-Mail: _____

Specialty Care Provider: _____

Specialty: _____ Date of First Visit: _____

Office Nurse/Medical Assistant: _____

Address: _____

Phone: _____ Fax: _____ E-Mail: _____

Account Number: ____________________

Specialty Care Provider: ____________________

Specialty: ____________________ Date of First Visit: ____________

Office Nurse/Medical Assistant: ____________________

Address: ____________________

Phone: ____________ Fax: ____________ E-Mail: ____________

Account Number: ____________________

Specialty Care Provider: ____________________

Specialty: ____________________ Date of First Visit: ____________

Office Nurse/Medical Assistant: ____________________

Address: ____________________

Phone: ____________ Fax: ____________ E-Mail: ____________

Account Number: ____________________

Specialty Care Provider: ____________________

Specialty: ____________________ Date of First Visit: ____________

Office Nurse/Medical Assistant: ____________________

Address: ____________________

Phone: ____________ Fax: ____________ E-Mail: ____________

Account Number: ____________________

Specialty Care Provider: ____________________

Specialty: ____________________ Date of First Visit: ____________

Office Nurse/Medical Assistant: ____________________

Address: ____________________

Phone:_____ Fax:_____ E-Mail:_____

Account Number: _____

Specialty Care Provider:_____

Specialty:_____ Date of First Visit:_____

Office Nurse/Medical Assistant:_____

Address:_____

Phone:_____ Fax:_____ E-Mail:_____

Account Number: _____

Specialty Care Provider:_____

Specialty:_____ Date of First Visit:_____

Office Nurse/Medical Assistant:_____

Address:_____

Phone:_____ Fax:_____ E-Mail:_____

Account Number: _____

Specialty Care Provider:_____

Specialty:_____ Date of First Visit:_____

Office Nurse/Medical Assistant:_____

Address:_____

Phone:_____ Fax:_____ E-Mail:_____

Account Number: _____

Therapists/Counselors

Occupational Therapist (OT): _____

Start Date: _____ End Date: _____

Agency/Hospital/Clinic: _____

Address: _____

Phone: _____ Fax: _____ E-Mail: _____

Physical Therapist (PT): _____

Start Date: _____ End Date: _____

Agency/Hospital/Clinic: _____

Address: _____

Phone: _____ Fax: _____ E-Mail: _____

Speech-Language Pathologist: _____

Start Date: _____ End Date: _____

Agency/Hospital/Clinic: _____

Address: _____

Phone: _____ Fax: _____ E-Mail: _____

Counselor/Social Worker: _____

Start Date:_____ End Date:_____

Agency/Hospital/Clinic:_____

Address:_____

Phone:_____ Fax:_____ E-Mail:_____

Other: _____

Start Date:_____ End Date:_____

Agency/Hospital/Clinic:_____

Address:_____

Phone:_____ Fax:_____ E-Mail:_____

Respite Care

Respite Care Provider: _____

Start Date: _____ End Date: _____

Agency: _____

Address: _____

Phone: _____ Fax: _____ E-Mail: _____

Respite Care Provider: _____

Start Date: _____ End Date: _____

Agency: _____

Address: _____

Phone: _____ Fax: _____ E-Mail: _____

Respite Care Provider: _____

Start Date: _____ End Date: _____

Agency: _____

Address: _____

Phone: _____ Fax: _____ E-Mail: _____

Additional Service/Support Providers

Case manager, advocate, Department of Family Services contacts, waiver, support groups, etc.

Services: _____

Agency: _____

Contact Person: _____ Phone: _____

Services: _____

Agency: _____

Contact Person: _____ Phone: _____

Services: _____

Agency: _____

Contact Person: _____ Phone: _____

Insert Business Cards Here

Child Care/Preschool/Child Development

Child Care/Preschool/Child Development Program: _____

_____

Address: _____

_____

Hours of Operation: _____

Phone: _____ Fax: _____

Director: _____ email: _____

Teacher: _____ email: _____

Service Providers (Case manager, Family Service Coordinator, therapists, nurse, etc.)

Child Care/Preschool/Child Development Program: _____

_____

Address: _____

_____

Hours of Operation: _____

Phone: _____ Fax: _____

Director: _____ email: _____

Teacher: _____ email: _____

Service Providers (Case manager, Family Service Coordinator, therapists, nurse, etc.)

Special Care Plan for Child Care Providers

Facility Name:_____

Facility Address:_____

Child's Name:_____

Date of Birth: _____ Times and Days in Child Care:_____

1. Describe the child's special need during group care:_____

_____

2. Child's present function level and skills:_____

_____

3. What emergency or unusual episode might arise while the child is in care? How should the situation be handled?_____

_____

4. Accommodation which the facility must provide for this child:_____

_____

   a. Are there particular instructions for sleeping, toileting, diapering or feeding?_____

   _____

   b. Will the child require medication while in care? If so, attach the physicians instructions for the use of the child's medication:_____

   _____

   c. Are special emergency and/or medical procedures required? If so, what procedures are required?_____

   _____

   d. Are special materials/equipment needed? _____

   _____

5. Other specialists working with the child (e.g. occupational or physical therapist): _____

_____

Primary Case Manager:_____ Phone:_____

(usually the doctor in charge)

Address:_____

On-site child care facility case manager: _____ Phone: _____