My Child's Emergency Contact Sheet

Name:	**Date of Birth:**
Home Address:	Phone:
	Alternate phone:

Parents & Emergency Contact Information

Parent/Guardian 1:	Cell:
Home Address:	Work / Home Phone:
	E-mail:

Parent/Guardian 2:	Cell:
Home Address:	Work / Home Phone:
	E-mail:

Emergency contact #1:	Phone:
Emergency contact #2:	Phone:

Allergies: Medications/Food/Other

Physicians/providers

Clinic name:	Phone:
Primary care provider:	Phone/direct/nurses' line:
Secondary/specialist:	Phone:

Other relevant information

Medication / Supplement list

	Name / Brand / Generic	Dose	Timing	Reason for taking	Notes
☐	*Example: "Children's Probiotic"*	*1/4 tsp oral*	*once daily*	*eczema*	*Mix with applesauce.*
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Appointment log

Date	Provider	Reason seen / other notes	Next appointment

Lab work / tests / procedures

Date	Test / procedure	Result	Comments

Insurance information

<table>
<tr><td>Patient Name:</td><td>Date of Birth:</td></tr>
<tr><td>Address:</td><td>Phone Number of insured:
Cell:

Home:

Work:</td></tr>
<tr><td>Primary Insurance Company:</td><td>Policy Number:</td></tr>
<tr><td>Name of Insured:</td><td>Insured’s DOB:</td></tr>
<tr><td>Insured’s Relationship to Patient:</td><td>Group Number:</td></tr>
<tr><td>Send Claim To:</td><td>Deductible:
Individual:

Family:</td></tr>
<tr><td colspan="2">Insured’s Employer (if relevant)</td></tr>
<tr><td colspan="2">Is prior authorization needed? Yes No</td></tr>
<tr><td colspan="2">Insurance phone / customer service / other contact</td></tr>
<tr><td colspan="2">Policy Notes. (Deductible, case manager, etc.)</td></tr>
</table>

Specialists:

Clinic name:	Phone:
Provider name:	Specialty:
Seen for:	

Clinic name:	Phone:
Provider name:	Specialty:
Seen for:	

Clinic name:	Phone:
Provider name:	Specialty:
Seen for:	

Clinic name:	Phone:
Provider name:	Specialty:
Seen for:	

Clinic name:	Phone:
Provider name:	Specialty:
Seen for:	

Breastfeeding log

Day:			
Time:	**Minutes:**	**Side:**	**Comments:**
		L / R	
		L / R	
		L / R	
		L / R	
		L / R	
		L / R	
		L / R	
		L / R	
		L / R	
		L / R	
		L / R	
Wet diapers (circle W for each wet diaper)	W W W W W W W W W		
Bowel movements / Poopy diapers	BM BM BM BM BM BM BM		
Other notes:			

Bottles / solid foods

Day:			
Time:	**Ounces / mL offered:**	**Ounces / mL consumed:**	**Other foods given (jars, BLW) approximate amounts:**
Total ounces consumed:			
Wet diapers (circle W for each wet diaper)	W W W W W W W W W		
Bowel movements / Poopy diapers	BM BM BM BM BM BM BM		
Comments:			

Notes