

Collaborative Care Notebook

**Adapted and Distributed by
the Utah Family Voices
Family to Family Health
Information Center in
collaboration with the
Bureau of Children with
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and the Utah Parent Center
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Maternal and Child Health
Bureau.**



**A Family-to-Family
Health Information
Center
For more information call
(801)584-8235**

About your Care Notebook

What is a Care Notebook?

A Care Notebook is an organizing tool for families who have children with special health care needs. Use a Care Notebook to keep track of important information about your child's health care. This Care Notebook has been designed for families of Children and Youth with Special Health Care Needs.

How can a Care Notebook help me?

In caring for your child with special health needs, you may get information and paperwork from many sources. A Care Notebook helps you organize the most important information in a central place. A Care Notebook makes it easier for you to find and share key information with others who are part of your child's care team.

About this Care Notebook

This version of a Care Notebook was "built" by a parent of a child with multiple special health care needs from the Utah Family Voices Family to Family Health Information center. This book can be used "as is" or you can remove or add pages according to your child's needs. Below, you can learn how to "build your own care notebook" from twenty different versions from different states. You may notice that the pages in this book all look different, and each page will indicate from which state or program it was created. The Utah Family Voices F2F Health Information Center found the process of building your own care notebook from the National Center for Medical Home Initiatives to be an innovative, creative, and easy way to put together a file for any child with special health care needs. It can be built to suit any variety of needs.

Why build my own care notebook?

The Care Notebook is an organizing tool for families and will help you keep track of important information. Care Notebooks are very personal to your child and ideally should be customized to reflect your child's medical history and current information. For this reason, the American Academy of Pediatrics-National Center for Medical Home Initiatives for Children with Special Health Care Needs has developed a section of their website to allow you to build a Care Notebook that best meets the needs of your child. Utah Family Voices recommends use of this website to create your individualized Care Notebook.

How do I build my own Care Notebook?

Go to http://www.medicalhomeinfo.org/tools/care_notebook.html
Twenty Care Notebooks have been divided into sections with similar content and made available in both Microsoft Word and PDF formats. Your computer must have Microsoft Word software to open and use the Word documents or to delete, modify, or add your own text to reflect the information you want to include in that particular section of your Child's Care Notebook. You will need the free Adobe Reader on your computer to open and view the PDF documents. You can fill-in and print completed PDF forms from the web site or print blank forms and complete them manually. You cannot save completed PDF forms unless you purchase and have Adobe Acrobat software on your computer. Most people will want to fill-in and save the Care Notebook documents and this is most easily done with the word documents. However, those who do not have Word software on their computer are able to use the PDF format version with the understanding that the forms cannot be altered (or changed). It is recommended to view the online examples before building your own care notebook.

Fill and update your Care Notebook:

-Track changes in your child's medicines or treatments

-Add new information to the Care Notebook whenever your child's treatment changes.

-List telephone numbers for providers and contacts

-Prepare for appointments

-File information about your child's health history

Use your Care Notebook:

-Store the Care Notebook where it is easy to find. This helps you and anyone who needs information when you are not there.

-Share new information with your child's primary care physician, school nurse, daycare staff, and others caring for your child

-Take the Care Notebook with you to appointments and hospital visits so that information you need will be easy to find.

-Include your child when working on the Care Notebook. Let them know that the Care Notebook contains information about them and their care.

Setting up Your Care Notebook

Follow these steps to set up your Care Notebook:

Step 1: Gather information you already have.

- ♥ Gather up any health information about your child you already have. This may include reports from recent doctor's visits, recent summary of a hospital stay, this year's school plan, test results, or informational pamphlets.

Step 2: Check out the pages of the Care Notebook

- ♥ Which of these pages could help you keep track of information about your child's health or care?
- ♥ Use the Care Notebook as it is, remove pages or get or more pages that will help you personalize your book to your child's needs are available at:
http://www.medicalhomeinfo.org/tools/care_notebook.html
- ♥ For a printed copy, call Utah Family Voices at 801-272-1068 or 1-800-468-1160.

Step 3: Decide which information is most important to keep in your child's Care Notebook

- ♥ What information do you look up often?
- ♥ What information do caregivers for your child need?
- ♥ Consider storing other information in a file drawer or box where you can find it if needed.

Step 4: Assemble your Care Notebook

- ♥ Everyone has a different way of organizing information. The KEY is to make it easy for **you** to find again. Here are some suggestions for supplies used to create a Care Notebook:
- ♥ **3-ring notebook** . Hold papers securely.
- ♥ **Tabbed dividers**. Create your own information sections.
- ♥ **Pocket dividers**. Store reports.
- ♥ **Plastic pages**. Store business cards and photographs.

Notes:

Care Notebook Contents

Myself

- ♥ Child Information Page - UT
- ♥ Child's Health Page - ND
- ♥ Family Information Page- UT
- ♥ Make a Calendar - ME
- ♥ Notes - UT

My Health Care

- ♥ Emergency Information Form-AAP
- ♥ Doctor's Appointments - TN
- ♥ Diagnoses - MA
- ♥ Nutrition - UT
- ♥ Diet Tracking Form - UT
- ♥ Growth Tracking Form - UT
- ♥ Immunizations and Allergy - IL
- ♥ Medications - TN
- ♥ Nebulizer & Vest Treatments - IL
- ♥ Catheterization Schedule - IL
- ♥ Respiratory – ND
- ♥ Dental – IL
- ♥ Surgeries / Procedures – TN
- ♥ Event Diary – MA
- ♥ Seizure / Behavior Log – CA
- ♥ Medical Supplies – IL
- ♥ Notes - UT

My Contacts

- ♥ Health Care Providers - IN
- ♥ Family Support Resources - IN
- ♥ School Contacts - UT
- ♥ Emergency Contacts - ME
- ♥ Personal Contacts - ME

- ♥ Contact Log - VA

- ♥ Notes - UT

My Plan

- ♥ Care Schedule - MO
- ♥ Mealtime Routine - TN
- ♥ Therapy - IL
- ♥ Activities of Daily Living - UT
- ♥ Social Experiences - OH
- ♥ Recreation – UT
- ♥ Communication – UT
- ♥ Communication Info. – UT
- ♥ Coping/Stress Tolerance – UT
- ♥ Mobility – UT
- ♥ Social/Play – UT
- ♥ Rest/ Sleep – UT
- ♥ Transition – UT
- ♥ Notes – UT

My Coverage

- ♥ Insurance – UT
- ♥ Medical Bill Communication - UT
- ♥ Tracking of Medical Bills – TN
- ♥ Medical Travel Expense Log – IL
- ♥ Out of Pocket Expense Log – CA
- ♥ Notes - UT

Note: You may use all or just a part of these pages. Not all of the pages may apply to your family situation. Look on the website to add different pages.

Organize your pages any way that works for you. (See "Setting up Your Care Notebook.")

Use dividers of tabs to help you organize your note book. Sheet protectors, plastic sleeves and folders will also be helpful.

Use the “Myself” section of your Care Notebook to create an identity profile for your child. This section includes a personal profile, family, friends and a calendar to schedule your child’s appointments and activities.

Myself

Child's Page

Photo of Me!

My name is:

My nickname is:

My birthday is:

I like to:

I don't like to:

I have a pet yes/no My pet is a _____ Named _____

My friends are _____

My caregivers are _____

When I am happy I _____

When I am sad I _____

When I feel pain I _____

I need help with _____

I can do these things for myself _____

If you need to know something else, call _____

My Favorite Things

Toys _____

TV shows _____

Games _____

Hobbies _____

Songs _____

Animals _____

Favorite foods _____

Least Favorite foods _____

Family Information

Child's Name: _____ Nickname: _____

Date of Birth: _____ Social Security Number: _____

Diagnosis: _____ Blood Type: _____

Legal Guardian: _____

Address: _____ Phone: _____

Mother's Name: _____

Address: _____

Daytime Phone: _____ Evening Phone: _____

Father's Name: _____

Address: _____

Daytime Phone: _____ Evening Phone: _____

Name: _____ Age: ____ Name: _____ Age: ____

Name: _____ Age: ____ Name: _____ Age: ____

Other household members:

Important Family Information:

Language(s) spoken at home: _____

Interpreter Needed? Yes: __ No: __

Preferred interpreter? Name: _____ Phone: _____

Emergency Contact

Name: _____

Address: _____

Daytime Phone: _____ Evening Phone: _____

"Make-A-Calendar"

Month _____ **Year** _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Name: _____ **DOB:** _____

The “My Health Care” section of your Care Notebook is to keep all information about your child’s health care and health care needs. This section will be very helpful at appointments with doctors and specialists.

My Health Care

**Emergency Preparedness for
Children with Special Health Care Needs**
Instructions for Parents

Dear Parent:

Children with special health care needs have very unique medical histories and require very special medical treatment. If an emergency physician does not have access to this important information, these children are in danger of delayed treatment, unnecessary tests, and even serious errors. It is extremely important, then, that parents and physicians work together to give emergency physicians access to the special information they need to properly care for children with very special health care needs.

To address this problem, the American Academy of Pediatrics and the American College of Emergency Physicians have developed the Emergency Information Form. This simple form is used to record health information for children with special health care needs and should be kept in multiple locations for easy access by physicians and emergency medical personnel.

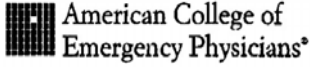
To complete this important form, follow these easy instructions:

1. **GET THE FORM:** Get the Emergency Information Form from the child's primary care physician, specialist, or the local emergency room.
2. **FILL IT OUT:** Begin filling out the form to the best of your ability. Take the form to the child's primary care physician or specialist and ask them to finish filling out the form.
3. **KEEP IT:** Keep 1 copy of the form in each of the following places:
 - a. **DOCTORS:** On file with each of the child's physicians, including specialists.
 - b. **ER:** On file with the local emergency rooms where the child is most likely to be treated in the case of an emergency.
 - c. **HOME:** At the child's home in a place where it can be easily found, such as the refrigerator.
 - d. **VEHICLES:** In each parent's vehicle (ie, glove compartment).
 - e. **WORK:** At each parent's workplace.
 - f. **PURSE/WALLET:** In each parent's purse or wallet.
 - g. **SCHOOL:** On file with the child's school, such as in the school nurse's office.
 - h. **CHILD'S BELONGINGS:** With the child's belongings when traveling.
 - i. **EMERGENCY CONTACT PERSON:** At the home of the emergency contact person listed on the form.
4. **REGISTER:** Consider registering the child, if he or she is not already registered, with MedicAlert®. Send MedicAlert® a copy of the form so that they can keep it stored in their central database, which is easily accessible by emergency medical personnel.
5. **UPDATE:** It is extremely important that you update the form every 2-3 years, and after any of the following events:
 - a. Important changes in the child's condition.
 - b. The performance of any major procedure.
 - c. Important changes in the treatment plan.
 - d. Changes in physicians.

Now, if your child ever has an emergency, the emergency medical personnel will have easy access to your child's very unique medical history, allowing them to provide your child with the best medical care available. Thank you for your cooperation!

Very truly yours,
American Academy of Pediatrics
American College of Emergency Physician
Emergency Medical Services for Children

Emergency Information Form for Children With Special Needs



American Academy
of Pediatrics



Date form completed	Revised	Initials
By Whom	Revised	Initials

Name:		Birth date:	Nickname:
Home Address:		Home/Work Phone:	
Parent/Guardian:		Emergency Contact Names & Relationship:	
Signature/Consent*:			
Primary Language:		Phone Number(s):	
Physicians:			
Primary care physician:		Emergency Phone:	
		Fax:	
Current Specialty physician:		Emergency Phone:	
Specialty:		Fax:	
Current Specialty physician:		Emergency Phone:	
Specialty:		Fax:	
Anticipated Primary ED:		Pharmacy:	
Anticipated Tertiary Care Center:			

Diagnoses/Past Procedures/Physical Exam:	
1.	Baseline physical findings:
2.	
3.	Baseline vital signs:
4.	
Synopsis:	Baseline neurological status:

*Consent for release of this form to health care providers

Physician/Provider Signature:	Print Name:
--------------------------------------	--------------------

Emergency Information Form

Diagnoses/Past Procedures/Physical Exam continued:

Medications:	Significant baseline ancillary findings (lab, x-ray, ECG):
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	Prostheses/Appliances/Advanced Technology Devices:
5. _____	_____
6. _____	_____

Management Data:

<i>Allergies: Medications/Foods to be avoided</i>	and why:
1. _____	_____
2. _____	_____
3. _____	_____
<i>Procedures to be avoided</i>	and why:
1. _____	_____
2. _____	_____
3. _____	_____

Immunizations (mm/yy)

Dates	Dates
DPT	Hep B
OPV	Varicella
MMR	TB status
HIB	Other

Antibiotic prophylaxis: _____ Indication: _____ Medication and dose: _____

Common Presenting Problems/Findings With Specific Suggested Managements

Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:

Physician/Provider Signature: _____ **Print Name:** _____

DOCTOR'S APPOINTMENTS

Doctor's Name	Appointment Date	Appointment Time	Questions to Ask at Appointment
			<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
			<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
			<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
			<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
			<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

Diet Tracking Form

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Tube Feeding							
Breakfast							
Lunch							
Dinner							
Snacks							
Notes							

Immunizations

IMMUNIZATION AND ALLERGY RECORD

Child's Name: _____

	Date	Physician	Reaction	Date	Physician	Reaction	Date	Physician	Reaction	Date	Physician	Reaction	Date	Physician	Reaction
Hepatitis B															
Diphtheria-Tetanus (Combined: DT)															
Diphtheria-Pertussis-Tetanus (Combined: DPT)															
Tetanus															
Polio															
Influenza Type B															
MMR (Measles, Mumps and Rubella)															
Measles (Rubeola)															
Mumps															
Rubella (3 day measles)															
Varicella Zoster															

	Date	Result	Date	Result	Date	Result
Tuberculin Test						
Lead Screening						
Other						

Allergies and Childhood Illnesses

Communicable Diseases:

	Date	Duration	Drugs Taken
7 day regular measles			
German Measles (rubella)			
Chickenpox			
Mumps			
Pertussis (whooping cough)			
Scarlet Fever			
Strep Throat			
Roseola			
Other (rashes, etc.)			

ALLERGY RECORD

Allergy	Type of Reaction	Date

Dental Record

DENTAL RECORD

Child's Name: _____

Dentist's Name: _____

Address: _____

Telephone: _____

Dentist has been informed of child's medical condition and medical specialists' recommendations.

All children should have routine dental care. Such care may be even more important when your child has a special health care need. He or she may need to be followed by a dentist with special skills. Consult with your family dentist or your child's medical specialist to determine if he or she requires specialized dental services.

Before your child is examined, the dentist should have information regarding your child's medical condition and current care. Any precautions recommended by your child's medical specialist should be discussed with the dentist. It is also essential that you provide the dentist with a list of current medications received by your child.

You may wish to use the space below to keep track of your child's dental appointments.

Date	Time	Appointment Information

Child's Name: _____

SURGERIES OR PROCEDURES

Type of surgery/procedure	Surgeon/Physician/Hospital	Date(s)

HOSPITAL ADMISSIONS (FOR REASONS OTHER THAN SURGERY)

Reason for admission	Hospital	Date(s)

Surgeries or Procedures

*Use the “My Contacts”
section fo your Care
Notebook for the people
who provide services and
give care to your child, and
are just a part of their life.
Include school, emergency,
and personal contacts.*

My Contacts

Health Care Providers

Primary Medical Provider _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Preferred Hospital _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Specialty Hospital _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Specialist Name _____ **Type** _____
Clinic/Hospital _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Specialist Name _____ **Type** _____
Clinic/Hospital _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Name _____ DOB _____

Health Care Providers

Specialist Name _____ **Type** _____
Clinic/Hospital _____
Address _____
City _____ **State** _____ **Zip** _____
Phone () _____
Email _____

Specialist Name _____ **Type** _____
Clinic/Hospital _____
Address _____
City _____ **State** _____ **City** _____
Phone () _____
Email _____

Specialist Name _____ **Type** _____
Clinic/Hospital _____
Address _____
City _____ **State** _____ **City** _____
Phone () _____
Email _____

Dentist Name _____
Address _____
City _____ **State** _____ **Zip** _____
Phone () _____
Email _____

Orthodontist Name _____
Address _____
City _____ **State** _____ **Zip** _____
Phone () _____
Email _____

Public Health Nurse

Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Nutritionist

Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Social Worker

Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Healthy Families Contact

Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Home Health Agency

Start Date _____ End Date _____
Contact Person _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Health Care Providers

Home Health Agency

Start Date _____ End Date _____
Contact Person _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Home Health Agency

Start Date _____ End Date _____
Contact Person _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Pharmacy

Contact Person _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Pharmacy

Contact Person _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Adapted from *Medical Passport* (unpaged) by the Indiana State Department of Health Children's Special Health Care Services, 1-800-475-1355, printed (n.d.), Project MCJ-18IS23-02

Occupational Therapist (OT)

Start Date _____ End Date _____
Agency _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Physical Therapist (PT)

Start Date _____ End Date _____
Agency _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Speech-Language Pathologist

Start Date _____ End Date _____
Agency _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Other Therapist

Start Date _____ End Date _____
Agency _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Other Therapist

Start Date _____ End Date _____
Agency _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Respite Care Provider

Start Date _____ End Date _____
Agency _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Family Support Resources

Parent-to-Parent

Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Parent Group

Address _____
City _____ City _____ City _____
Phone () _____
Email _____

Religious Organization

Address _____
City _____ City _____ City _____
Phone () _____
Email _____

Service Organization

Address _____
City _____ City _____ City _____
Phone () _____
Email _____

Counseling Services

Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Other

Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Child's Name _____ DOB _____

School/Preschool

Principal _____
School Contact _____
Start Date _____ End Date _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

School Nurse

Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Teacher

Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Special Education Teacher

Address _____
City _____ City _____ City _____
Phone () _____
Email _____

Other

Address _____
City _____ City _____ City _____
Phone () _____
Email _____

Other

Address _____
City _____ City _____ City _____
Phone () _____
Email _____

Transportation Agency

Contact Person _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Transportation Agency

Contact Person _____
Address _____
City _____ City _____ City _____
Phone () _____
Email _____

Respite Care Provider

Start Date _____ End Date _____
Agency _____
Address _____
City _____ State _____ Zip _____
Phone _____) _____
Email _____

Respite Care Provider

Start Date _____ End Date _____
Agency _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

Respite Care Provider

Start Date _____ End Date _____
Agency _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Email _____

School Contacts

(Some parents store IEP and 504 plan information in sheet protectors following this section.)

School Contacts

• **School District:** _____
Address: _____

Phone: _____ Fax: _____ Web Site: _____

Special Education Coordinator: _____

Address: _____

Phone: _____ Fax: _____ Web Site: _____

504 Accommodation Plan Coordinator: _____

Address: _____

Phone: _____ Fax: _____ Web Site: _____

District Nurse assigned to your child's school: _____

Address: _____

Phone: _____ Fax: _____ Web Site: _____

• **School / Preschool:** _____

Address: _____

Phone: _____ Fax: _____ Web Site: _____

Principal / Administrator: _____

Phone: _____ Fax: _____ Web Site: _____

Classroom Teacher: _____

Phone: _____ Fax: _____ Web Site: _____

Resource Instructor: _____

Phone: _____ Fax: _____ Web Site: _____

Aide / Assistant / Intervener: _____

Phone: _____ Fax: _____ Web Site: _____

Special Education Director / Teacher(s): _____

Phone: _____ Fax: _____ Web Site: _____

Therapist(s): _____

Phone: _____ Fax: _____ Web Site: _____

Other Contacts: _____

Emergency Contact Person(s)

Name _____

Address _____

City _____ State _____ Zip _____

Phone () _____ Relationship _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone () _____ Relationship _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone () _____ Relationship _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone () _____ Relationship _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone () _____ Relationship _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone () _____ Relationship _____

Name _____ DOB _____

Personal Contacts

Personal Contacts

Name/Address	Phone _____
	Office _____
	Fax _____
	Cell _____
	Email _____

Name/Address	Phone _____
	Office _____
	Fax _____
	Cell _____
	Email _____

Name/Address	Phone _____
	Office _____
	Fax _____
	Cell _____
	Email _____

Name/Address	Phone _____
	Office _____
	Fax _____
	Cell _____
	Email _____

Name/Address	Phone _____
	Office _____
	Fax _____
	Cell _____
	Email _____

Name: _____ **DOB:** _____

The “My Plan” section of your Care Notebook is where you can lay out what is happening in your child’s life and what you would like to see happen in the future, This includes daily care, mealtime routine, therapies recreation, communication, play, and more.

My Plan

MEALTIME ROUTINE

Usual eating times: _____

Usual length of time to eat: _____

Food allergies

Foods to avoid

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Favorite foods / food dislikes: _____

Feeding equipment / utensils used / positioning: _____

Feeding tips: _____

Mealtime Routine

Social Experiences

What activities make life meaningful for your son or daughter? What leisure activities does your child enjoy? List all hobbies, interests recreational and social activities and vacation preferences. Make a list of place and situation that your child is uncomfortable with or dislikes.

Favorite TV shows/movies

Hobbies/Activities in the home

Leisure Activities/Clubs outside the home

Name of Club _____

Contact Person _____

Phone Number _____

How Often _____

Name of Club _____

Contact Person _____

Phone Number _____

How Often _____

Special Interests

(Example: loves Cincinnati Reds Games in person but not on TV)

Favorite Vacations/Travels

Recreation

A number of organizations have programs designed to give children and adults with special needs Recreation opportunities. These include local park and recreation programs. Check with your providers to find out more about recreation opportunities close to your home. Some parents include brochures and activity calendars in this section of their Care Notebook.

☼ Recreation Opportunity: _____
Contact Person: _____
Address: _____
Phone: _____ Fax: _____ E-Mail: _____
Schedule: _____

☼ Recreation Opportunity: _____
Contact Person: _____
Address: _____
Phone: _____ Fax: _____ E-Mail: _____
Schedule: _____

☼ Recreation Opportunity: _____
Contact Person: _____
Address: _____
Phone: _____ Fax: _____ E-Mail: _____
Schedule: _____

☼ Recreation Opportunity: _____
Contact Person: _____
Address: _____
Phone: _____ Fax: _____ E-Mail: _____
Schedule: _____

☼ Recreation Opportunity: _____
Contact Person: _____
Address: _____
Phone: _____ Fax: _____ E-Mail: _____
Schedule: _____

Notes:

My Coverage

The “My Coverage” section is where you can record all information on Health Care Coverage, Medical Bills, correspondence, and out of pocket expenses.

Insurance, Etc.

☼ Insurance Name: _____
Policy Number: _____
Contact Person/Title: _____
Address: _____
Phone: _____ Fax: _____

☼ Medicaid (HMO Name if applicable – this is the company name that appears above your child’s name and ID Number on the Medicaid Identification Card): _____
Policy Number: _____
Contact Person/Title: _____
Address: _____
Phone: _____ Fax: _____

☼ Insurance Name: _____
Policy Number: _____
Contact Person/Title: _____
Address: _____
Phone: _____ Fax: _____ Website/Email: _____

☼ Supplemental Security Income (SSI): _____
Contact Person/Title: _____
Address: _____
Phone: _____ Fax: _____ Website/Email: _____

☼ Other: _____
Contact Person/Title: _____
Address: _____
Phone: _____ Fax: _____ Website/Email: _____

☼ Other: _____
Contact Person/Title: _____
Address: _____
Phone: _____ Fax: _____ Website/Email: _____

