

ALL

ABOUT

A large, empty rectangular box with a thin black border, intended for a student to write their response to the question.

ME!

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Emergency Information:

My Name is: _____ Nickname: _____

My Address is:

Directions to my house:

The language we speak at home: _____

Do I need an Interpreter Yes _____ No _____

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**Fire** Department Number: 911 or  
\_\_\_\_\_

**Police** Department Number: 911 or  
\_\_\_\_\_

**Ambulance** 911 or  
\_\_\_\_\_

**Poison** Control Hotline  
\_\_\_\_\_

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Fire Escape Plan: _____


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**Check smoke alarms monthly!**  
**Check fire extinguishers monthly!**

**Family and Friends Emergency Contact Information**

Name\_\_\_\_\_ Relationship\_\_\_\_\_

Address\_\_\_\_\_ City/Zip\_\_\_\_\_

Telephone\_\_\_\_\_ Day \_\_\_\_\_ Evening

Cell Phone or Alternate number(s)\_\_\_\_\_

~~~~~

Name_____ Relationship_____

Address_____ City/Zip_____

Telephone_____ Day _____ Evening

Cell Phone or Alternate number(s)_____

~~~~~

Name\_\_\_\_\_ Relationship\_\_\_\_\_

Address\_\_\_\_\_ City/Zip\_\_\_\_\_

Telephone\_\_\_\_\_ Day \_\_\_\_\_ Evening

Cell Phone or Alternate number(s)\_\_\_\_\_

~~~~~

Name_____ Relationship_____

Address_____ City/Zip_____

Telephone_____ Day _____ Evening

Cell Phone or Alternate number(s)_____

Doctor, Specialist, Pharmacy Contact Information

Primary Care Provider: _____

Address: _____

Phone: _____ Fax: _____

Emergency/After Hours Number: _____

~~~~~

**Urgent Care/After Hours Clinic** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Emergency/After Hours Number: \_\_\_\_\_

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Primary Hospital _____

Address: _____

Phone: _____ Fax: _____

Emergency/After Hours Number: _____

~~~~~

**Secondary Hospital** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Emergency/After Hours Number: \_\_\_\_\_

~~~~~

Counselor/Therapist: _____

Address: _____

Phone: _____ Fax: _____

Emergency/After Hours Number: _____

~~~~~

**Specialist Provider** \_\_\_\_\_ **Specialty:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Emergency/After Hours Number: \_\_\_\_\_

~~~~~

Specialist Provider: _____ **Specialty:** _____

Address: _____

Phone: _____ Fax: _____

Emergency/After Hours Number: _____

~~~~~

**Specialist Provider:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Emergency/After Hours Number: \_\_\_\_\_

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Dentist: _____

Address: _____

Phone: _____ Fax: _____

Emergency/After Hours Number: _____

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**Physical Therapist:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Emergency/After Hours Number: \_\_\_\_\_

~~~~~

Occupational Therapist: _____

Address: _____

Phone: _____ Fax: _____

Emergency/After Hours Number: _____

~~~~~

**Speech-Language Pathologist:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Emergency/After Hours Number: \_\_\_\_\_

~~~~~

Eye Care Provider: _____

Address: _____

Phone: _____ Fax: _____

Emergency/After Hours Number: _____

~~~~~

**Pharmacy** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Emergency/After Hours Number: \_\_\_\_\_

~~~~~

Pharmacy _____

Address: _____

Phone: _____ Fax: _____

Emergency/After Hours Number: _____

~~~~~

**TRANSPORTATION:**

**Agency:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Emergency/After Hours Number: \_\_\_\_\_

~~~~~

Agency: _____

Address: _____

Phone: _____ Fax: _____

Emergency/After Hours Number: _____

~~~~~

**Agency:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Emergency/After Hours Number: \_\_\_\_\_

~~~~~

Agency: _____

Address: _____

Phone: _____ Fax: _____

Emergency/After Hours Number: _____

Community Contact Information:

School Name: _____

Grade or year in school: _____

School Phone: _____ Contact Person: _____

Academic Counselor: _____ Phone: _____

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Department of Health and Human Services Case Number: \_\_\_\_\_

Case Manager/Title: \_\_\_\_\_

Address: \_\_\_\_\_

Daytime phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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Other Case Management: _____

Case Manager/Title: _____

Address: _____

Daytime phone: _____ Evening Phone: _____ Fax: _____

~~~~~

Durable Medical Equipment Company: \_\_\_\_\_

Case Manager/Title: \_\_\_\_\_

Address: \_\_\_\_\_

Daytime phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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Church or Religious Community: _____

Contact Person: _____

Address: _____

Daytime Phone: _____ Evening Phone: _____

Consent for Treatment

Date last updated

Date: _____

In case of emergency, I authorize the following named person(s) listed below to give my consent to be hospitalized, have surgery or receive other necessary healthcare:

Name	Relationship
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	

This permission remains in effect until I change it by completing a new form.

Signature or Legal Guardian

Date

Signature of Witness (not related to the child or parent/legal guardian)

MY STORY

Birth Information

I was born on _____ (Date of Birth). Social Security Number _____/_____/_____

My parent's names are: _____

Things I need help with (like washing, dressing or brushing teeth): _____

Things I can do for myself (but thanks for asking!): _____

If you need to know something else, ask me or ask _____

Who can be reached by calling: () _____

Important people who take care of me _____

Phone: _____

My Brothers and Sisters:

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

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

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

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

Medical History (You can ask your doctor or nurse to help you fill this out)

Nutrition / Diet:

Last Updated _____

Important Baseline Information (Sats, neurological baseline, etc.)

Durable Medical Equipment (DME) / Appliances and Providers

Hospital Stays

Approximate Dates

1. _____

2. _____

3. _____

4. _____

5. _____

Surgeries / Procedures

Approximate Dates

1. _____

2. _____

3. _____

4. _____

5. _____

Other Treatments

Medicines/Allergies

Pharmacy Name:

Phone:

Fax:

(Write meds in pencil only, please)

Current Medicines I'm taking	How do I take it, How much, How often
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Medications that didn't work: (ALLERGIES)

Name of Drug	Date Started	Date Ended	How much/ How often	Reason for Stopping

Immunization and Preventable Disease History

Insert a copy of your immunization record here. **(Shot record)**

Disease History:

Immunizations and date given:

Chicken Pox _____

Hepatitis B _____

Hepatitis A _____

Other _____

Other _____

Other _____

Other _____

Other _____

This would be a good place to put your records of your immunizations and other information of the medication you are taking.

Thinking About Your Future

Circle, check or complete the answer that is true for you.

1. Education and Employment

What are your plans for the next five years? (Check all that apply)

- Get a job/keep working
- Go to/finish high school
- Go to/finish a vocational, technical or other training program:
- Go to/finish a community college (2-year college)
- Go to/finish a 4-year college or University
- Other: _____

What kind of jobs would you like to have?

2. Living Arrangements

As an I adult, I plan to live (Check the one best answer)

- In my own house or apartment (by myself or with a spouse or roommates)
- With my parents
- With other members of my family (brother, sister, aunt)
- In supported community housing (group home)
- Another place (specify): _____

3. Living independently

As an adult, I think I will:

Manage my own money	Yes	No
Be financially independent; self-supporting	Yes	No
Be independently mobile in my home	Yes	No
Be independently mobile in the community	Yes	No
Drive a car or van	Yes	No
Manage a household	Yes	No
Get married or have a steady partner	Yes	No
Raise a family	Yes	No
Maintain friendships	Yes	No
Communicate well with health care providers	Yes	No
Arrange for and manage my own health care.	Yes	No
Pay for my own health insurance	Yes	No

4. Planning

I talk with my parents about my future.	Yes	No
I talk with my friends about my future.	Yes	No
I talk with my doctors and/or other professionals about my future	Yes	No

Other Transition Areas To Consider:

Other questions to answer are:

- **Do I need a vocational rehabilitation advisor to transition from school to work? If yes...**

Name of Contact: _____

Phone number: _____

Date Contact Initiated: _____

First Meeting Date: _____

TO DO List Prior to the First Meeting:

- **Do I need an independent living advisor to transition from home to adult living? If yes...**

Name of Contact: _____

Phone number: _____

Date Contact Initiated: _____

First Meeting Date: _____

TO DO List Prior to the First Meeting:

Do I need any additional help transitioning from secondary school to college or technical school? If yes...

Name of Contact: _____

Phone number: _____

Date Contact Initiated: _____

First Meeting Date: _____

TO DO List Prior to the First Meeting:

• Do I need help managing my transportation needs in order to meet my transition goals?

If yes...

Name of Social Worker: _____

Phone number: _____

Date Contact Initiated: _____

First Meeting Date: _____

TO DO List Prior to the First Meeting:

Preferences: Likes and Dislikes

My hobbies are:

My favorite things to do:

Activities I am involved in _____

I am unique because _____

Financial and Insurance Information/Considerations

Include a copy of your Insurance Card and Social Security Card in this Section

- Ask Yourself:
- Do I need a referral?
 - Does my insurance change with age or school status?
 - Does my insurance change with employment status?
 - If my insurance changes, are there certain services that will be less available after I reach a certain age?

**IF YOU CAN'T ANSWER THE QUESTIONS ABOVE
THE TIME TO FIND OUT ABOUT YOUR COVERAGE IS NOW!!**

~~~~~  
Primary Insurance: \_\_\_\_\_ Plan number: \_\_\_\_\_

Group number: \_\_\_\_\_ ID number: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_

Subscriber's Social Security Number: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

~~~~~  
Secondary Insurance: _____ Plan number: _____

Group number: _____ ID number: _____

Subscriber's name: _____

Subscriber's Social Security Number: _____

Mailing address: _____

Phone: _____ Fax: _____
~~~~~

Other Insurance: \_\_\_\_\_ Plan number: \_\_\_\_\_

Group number: \_\_\_\_\_ ID number: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_

Subscriber's Social Security Number: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Other Financial Information:**

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Place any important information or papers in the divided folders or plastic sheets to keep from losing the information.

- Do I have any other needs that need to be met prior to implementing my Transition plan? If yes list them here and talk to your doctor.

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**Congratulations!!**  
**You're ready to Transition!**







# MONTHLY CALENDAR

| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|--------|--------|---------|-----------|----------|--------|----------|
|        |        |         |           |          |        |          |
|        |        |         |           |          |        |          |
|        |        |         |           |          |        |          |
|        |        |         |           |          |        |          |
|        |        |         |           |          |        |          |

## **RESOURCES**

For more information about special health care services for children and youth,  
please refer to the following websites and phone numbers

|                                                                         |                                                                                                                             |
|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| Oklahoma Department of Human Services                                   | <a href="http://www.okdhs.org">www.okdhs.org</a> (405) 521-3646                                                             |
| Oklahoma Developmental Disabilities Council                             | <a href="http://www.okddc.ok.gov">http://www.okddc.ok.gov</a> (800) 836-4470                                                |
| Community Leadership and Advocacy, Center for Learning/Leadership/UCEDD | <a href="http://w3.ouhsc.edu/thecenter">http://w3.ouhsc.edu/thecenter</a> (800) 627-6827                                    |
| Maternal and Child Health Service                                       | <a href="http://www.health.state.ok.us">http://www.health.state.ok.us</a> (405) 271-4480                                    |
| Office of Juvenile Affairs                                              | <a href="http://www.oja.state.ok.us">www.oja.state.ok.us</a> (405) 530-2800                                                 |
| Oklahoma Commission on Children/Youth                                   | <a href="http://www.okkids.org">www.okkids.org</a> (866) 335-9288                                                           |
| Oklahoma Department of Mental Health and Substance Abuse Services       | <a href="http://www.odmhsas.org">www.odmhsas.org</a> (405) 522-3908                                                         |
| Oklahoma Department of Rehabilitation                                   | <a href="http://www.okrehab.org/">www.okrehab.org/</a> (800) 845-8476                                                       |
| Oklahoma Family Network Inc.                                            | <a href="http://www.oklahomafamilynetwork.org">www.oklahomafamilynetwork.org</a> (405) 271-4500                             |
| Oklahoma Health Care Authority                                          | <a href="http://www.okhca.org">www.okhca.org</a> (800) 522-0310                                                             |
| Oklahoma State Department of Education                                  | <a href="http://www.sde.state.ok.us">www.sde.state.ok.us</a> (405) 521-3301                                                 |
| Oklahoma State Department of Health                                     | <a href="http://www.health.state.ok.us">http://www.health.state.ok.us</a> (800) 522-0203                                    |
| Special Education Services                                              | <a href="http://www.sde.state.ok.us">www.sde.state.ok.us</a> (405) 522-3248                                                 |
| STARS (Statewide Training and Regional Support)                         | <a href="http://www.ah.ouhsc.edu/tolbert/courses_workshops/">www.ah.ouhsc.edu/tolbert/courses_workshops/</a> (405) 271-1836 |

### Additional websites:

ADA Accessibility Guidelines: <http://www.access-board.gov/adaag/html/adaag.htm>

Autism Society of America: <http://www.autism-society.org/site/PageServer>

Down Syndrome Association of Central Oklahoma: <http://www.dsaco.org/>

Down Syndrome Association of Tulsa: <http://www.dsat.org/>

IDEA (Individuals with Disabilities Education Act 2004): <http://www.nichey.org/idealaw.htm>

IMPACT-Articles on Autism Spectrum Disorder: <http://ici.umn.edu/products/impact/193/default.html>

Natural Resources: [http://www.fpg.unc.edu/~scpp/nat\\_allies/na\\_resources.cfm](http://www.fpg.unc.edu/~scpp/nat_allies/na_resources.cfm)

**NICHY (National Dissemination Center for Children with Disabilities): <http://www.nichcy.org/>**

**OASIS (Oklahoma's Statewide Information and Referral System): <http://oasis.ouhsc.edu/>**

**Oklahoma Assistive Technology Center: <http://www.theoatc.org/>**

**Oklahoma Autism Network: <http://www.okautism.org/>**

**Oklahoma Deaf-Blind Technical Assistance Project: <http://www.ou.edu/okdbp/techserv.html>**

**Oklahoma Medical Home (resources for families and providers): <http://www.medicalhomeportal.org/>**

**Oklahoma Yellow Page for Kids: <http://www.yellowpagesforkids.com/help/ok.htm>**

**Special Education Policies and Procedures: <http://www.sde.state.ok.us/pro/spedpp.html>**

**Special Quest: <http://www.specialquest.org/>**

**The RISE School: <http://www.riseschool.org/>**

**Tulsa Autism Foundation: <http://www.autismtulsa.org/home/index.cfm>**

**US Department of Education: <http://www.ed.gov/index.jhtml>**

**See enclosed pamphlet for 211 - A quick guide to Social Services**

**For more information about Sooner SUCCESS visit our website at [www.oumedicine.com/soonersuccess](http://www.oumedicine.com/soonersuccess)**