Dear Parents,

This Care Notebook has been developed just for you—parents with children with special health care needs. We offer this Notebook to you with deep appreciation for the central role you play in the life and care of your child. We hope it will serve as a guide in organizing and keeping track of your child’s records, appointments, and other important information. The Care Notebook is produced by the Center for Children with Special Needs and the Washington State Department of Health, Children with Special Health Care Needs Program, with invaluable input from parents and community professionals.

Families tell us they value having a central place to keep information they can easily take to appointments.

“I used a paper bag for my file! It took forever to find what I needed! Now I can just turn to the right section.”

“This way I don’t have to keep it all in my head.”

“I’d use the notebook to organize my thoughts and concerns before a doctor’s appointment. It gave me confidence and credibility.”

Families also use the Notebook to improve communication with doctors and other health care providers.

“Didn’t have to repeat information...I’ve taken it to all the doctors and when they ask what happened, I just pull out the notebook and show them.”

“I use the notes as a diary. I write down what the doctor has said, word for word. This really helps when I go to the next doctor and he wants to know what that doctor said.”

We encourage you to make this Notebook work for you! Create your own sections; remove and rearrange pages to fit your needs; and personalize it with drawings, stickers, photographs, and special articles and resources you’ve found helpful. The Care Notebook pages may be downloaded and printed from [http://www.cshcn.org](http://www.cshcn.org). You can find other resources and information for you and your family at this website.

If you have suggestions or comments about the Care Notebook, please feel free to contact Megan Sety at (206) 987-5310 or megan.sety@seattlechildrens.org.

Most sincerely,

Kathy Fennell
Manager

Megan Sety
Program Assistant
Care Notebook: A Quick Guide

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 and care.

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.

Use your Care Notebook to:

- Track changes in your child’s medicines or treatments
- List telephone numbers for health care providers and community organizations
- Prepare for appointments
- File information about your child’s health history
- Share new information with your child’s primary doctor, public health or school nurse, daycare staff, and others caring for your child

What are some helpful hints for using my child’s Care Notebook?

- Store the Care Notebook where it is easy to find. This helps you and anyone who needs information in your absence.
- Add new information to the Care Notebook whenever there is a change in your child’s treatment.
- Consider taking the Care Notebook with you to appointments and hospital visits so that information you need will be close at hand.

How do I set up my child’s Care Notebook?

Follow these steps to set up your child’s notebook:

Step 1: Gather information you already have.

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

Step 2: Look through the pages of the Care Notebook.

- Which of these pages could help you keep track of information about your child’s health or care?
- Choose the pages you like. Print copies of any that you think you will use. The Care Notebook pages are available from the Internet at http://www.cshcn.org. Go to “Resources” and then choose “Care Organizing Tools.”

Step 3: Decide which information about your child is most important to keep in the Care Notebook.

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

Step 4: Put the Care Notebook together.

- Everyone has a different way of organizing information. The only important thing 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 or large accordion envelope. Hold papers securely.
  - tabbed dividers. Create your own information sections.
  - pocket dividers. Store reports.
  - plastic pages. Store business cards and photographs.
# Care Notebook
## List of Pages

### Pages to Keep Track of Appointments and Care
- Appointment Log
- Diet Tracking Form
- Emergency Information Form
- Equipment/Supplies
- Growth Tracking Form
- Hospital Stay Tracking Form
- Lab Work/Tests/Procedures
- Make-a-Calendar
- Medical Bill Tracking Form
- Medical/Surgical Highlights
- Medications
- Notes

### Pages to Create a Care Summary: Abilities and Special Care Needs
- Activities of Daily Living
- Care Schedule
- Child’s Page—Now and Later
- Communication
- Coping/Stress Tolerance
- Mobility
- Nutrition
- Respiratory
- Rest/Sleep
- Social/Play
- Transitions—Looking Ahead

### Pages to Create a Care Team and Resources List
- Children's Hospital and Regional Medical Center
- Community Health Care/Service Providers:
  - Medical/Dental
  - Public Health
  - Home Care
  - Therapists
  - Early Intervention Services
  - School
  - Child Care
  - Respite Care
  - Pharmacy
  - Special Transportation
- Family Information
- Family Support Resources
- Funding Sources
- Alphabet Soup Acronym Index
Family Information

- Child’s Name: ___________________________ Nickname: ___________________________
  Date of Birth: ___________________ Social Security Number: ___________________________
  Diagnosis: ___________________________ _____________________________________________
  Blood Type: ___________________________ _____________________________________________
  Legal Guardian: ______________________________________________________________
  Address: _______________________________ Phone: _________________________________

Family Members

- Mother’s Name: ___________________________
  Social Security Number: ___________________________
  Address: ___________________________________________
  Daytime Phone: ___________________________ Evening Phone: ___________________________

- Father’s Name: ___________________________
  Social Security Number: ___________________________
  Address: ___________________________________________
  Daytime Phone: ___________________________ Evening Phone: ___________________________

- Sibling’s Name: ___________________________ Age: _____ Name: ___________________________ Age: _____
  Sibling’s Name: ___________________________ Age: _____ Name: ___________________________ Age: _____

- Other household members: _________________________________________________________

- Important Family Information: _______________________________________________________
  ________________________________________________________________

- Language spoken at home: _________________________________________________________
  Other language(s): ________________________________________________________________
  Interpreter Needed? Yes: ______ No: ________
  Interpreter: _______________________________ Phone: _________________________________

Emergency Contact

- Name: ___________________________________________
  Address: ___________________________________________
  Daytime Phone: ___________________________ Evening Phone: ___________________________
Family Support
Resources

• Parent to Parent: ____________________________
  Contact Person: ____________________________
  Address: ______________________________________
  ______________________________________
  Phone: __________________ Fax: __________________

• Parent Group: ____________________________
  Contact Person: ____________________________
  Address: ______________________________________
  ______________________________________
  Phone: __________________ Fax: __________________

• Religious Organization: ____________________________
  Contact Person: ____________________________
  Address: ______________________________________
  ______________________________________
  Phone: __________________ Fax: __________________

• Service Organization: ____________________________
  Contact Person: ____________________________
  Address: ______________________________________
  ______________________________________
  Phone: __________________ Fax: __________________

• Counseling Services: ____________________________
  Contact Person: ____________________________
  Address: ______________________________________
  ______________________________________
  Phone: __________________ Fax: __________________

(continued)
Family Support
Resources

- Division of Developmental Disabilities:
  
  Contact Person:
  
  Address:
  
  Phone: ______________________ Fax: ______________________

- Other:
  
  Contact Person:
  
  Address:
  
  Phone: ______________________ Fax: ______________________
Funding Sources

- Insurance Name: ____________________________________________
  Policy Number: ____________________________________________
  Contact Person / Title: ______________________________________
  Address: ___________________________________________________
  ___________________________________________________________
  Phone: ____________________ Fax: _____________________________

- Insurance Name: ____________________________________________
  Policy Number: ____________________________________________
  Contact Person / Title: ______________________________________
  Address: ___________________________________________________
  ___________________________________________________________
  Phone: ____________________ Fax: _____________________________

- Insurance Name: ____________________________________________
  Number: ___________________________________________________
  Contact Person / Title: ______________________________________
  Address: ___________________________________________________
  ___________________________________________________________
  Phone: ____________________ Fax: _____________________________

- Supplemental Security Income (SSI): __________________________
  Contact Person / Title: ______________________________________
  Address: ___________________________________________________
  ___________________________________________________________
  Phone: ____________________ Fax: _____________________________

(continued)
Funding Sources

- Other:______________________________________________________
  Contact Person / Title:__________________________________________
  Address:_____________________________________________________
  _______________________________ _______________________________
  Phone:________________________ Fax:__________________________

- Other:______________________________________________________
  Contact Person / Title:__________________________________________
  Address:_____________________________________________________
  _______________________________ _______________________________
  Phone:________________________ Fax:__________________________
Medical Record Number: ____________________________________________

• CHRMC Clinic:________________________________________________________
  Date of First Visit:_______________________________________________________
  Physician:_______________________________________________________________
  Contact Person / Title:______________________________________________________
  Phone:__________________________ Fax:_______________________________

• CHRMC Clinic:__________________________________________________________
  Date of First Visit:_______________________________________________________
  Physician:_______________________________________________________________
  Contact Person / Title:______________________________________________________
  Phone:__________________________ Fax:_______________________________

• CHRMC Clinic:__________________________________________________________
  Date of First Visit:_______________________________________________________
  Physician:_______________________________________________________________
  Contact Person / Title:______________________________________________________
  Phone:__________________________ Fax:_______________________________
Medical / Dental
Community Health Care Providers

- Primary / Community Care Provider: ________________________________
  Date of First Visit: _____________________________________________
  Office Nurse: _________________________________________________
  Address: ______________________________________________________
  _____________________________________________________________
  Phone: ____________________________ Fax: ________________________

- Community Hospital: _________________________________________
  Medical Record Number: _______________________________________
  Address: _____________________________________________________
  _____________________________________________________________
  Phone: ____________________________ Fax: ________________________

- Community Specialty Care Provider: _____________________________
  Date of First Visit: _____________________________________________
  Address: _____________________________________________________
  _____________________________________________________________
  Phone: ____________________________ Fax: ________________________

- Community Specialty Care Provider: _____________________________
  Date of First Visit: _____________________________________________
  Address: _____________________________________________________
  _____________________________________________________________
  Phone: ____________________________ Fax: ________________________

- Dentist / Orthodontist: _________________________________________
  Date of First Visit: _____________________________________________
  Address: _____________________________________________________
  _____________________________________________________________
  Phone: ____________________________ Fax: ________________________
Public Health
Community Health Care / Service Providers

- Public Health Department: __________________________________________________________
  Address: _______________________________________________________________________
  ________________________________________________________
  Phone: ______________________ Fax: _____________________________________________

- Public Health Nurse: _____________________________________________________________
  Phone: ______________________ Date of First Visit: _________________________________

- Nutritionist: _________________________________________________________________
  Phone: ______________________ Date of First Visit: _________________________________

- Social Worker: ________________________________________________________________
  Phone: ______________________ Date of First Visit: _________________________________

- Other: _________________________________________________________________
  Phone: ______________________ Date of First Visit: _________________________________
Home Care
Community Health Care / Service Providers

- Home Nursing Agency: __________________________________________________________

  Start Date: ________________________________

  Contact Person: ____________________________________________________________

  Address: _________________________________________________________________

  _________________________________________________________________

  Phone: ____________________ Fax: ____________________

- Home Nursing Agency: __________________________________________________________

  Start Date: ________________________________

  Contact Person: ____________________________________________________________

  Address: _________________________________________________________________

  _________________________________________________________________

  Phone: ____________________ Fax: ____________________

- Home Nursing Agency: __________________________________________________________

  Start Date: ________________________________

  Contact Person: ____________________________________________________________

  Address: _________________________________________________________________

  _________________________________________________________________

  Phone: ____________________ Fax: ____________________
Therapists
Community Health Care / Service Providers

Therapists:

• Occupational Therapist (OT): ____________________________
  Start Date: ______________________________________________________________________
  Agency: __________________________________________________________________________
  Address: __________________________________________________________________________
  _______________________________ ____________________________________________________
  Phone: __________________ Fax: __________________

• Physical Therapist (PT): ________________________________
  Start Date: ______________________________________________________________________
  Agency: __________________________________________________________________________
  Address: __________________________________________________________________________
  _______________________________ ____________________________________________________
  Phone: __________________ Fax: __________________

• Speech-Language Pathologist: __________________________
  Start Date: ______________________________________________________________________
  Agency: __________________________________________________________________________
  Address: __________________________________________________________________________
  _______________________________ ____________________________________________________
  Phone: __________________ Fax: __________________
Early Intervention Services
Community Health Care / Service Providers

- Developmental Center: ________________________________________________________________

  Start Date: ____________________________________________

  Contact Person: _________________________________________

  Address: ______________________________________________

  _______________________________________________________

  Phone: ___________________________ Fax: __________________

- Family Resources Coordinator: _____________________________

  Start Date: ____________________________________________

  Agency: ________________________________________________

  Address: ______________________________________________

  _______________________________________________________

  Phone: ___________________________ Fax: __________________
School
Community Health Care / Service Providers

- School / Preschool:
  
  Start Date:
  
  Address:

  Phone: __________________ Fax: __________________

- School Nurse:
  
  Phone: __________________ Fax: __________________

- Contact Person / Title:
  
  Phone: __________________ Fax: __________________

- Contact Person / Title:
  
  Phone: __________________ Fax: __________________
Child Care Provider: ____________________________________________

Start Date: _________________________________

Contact Person: ____________________________________________

Address: _________________________________________________

__________________________________________________________

Phone: ___________________ Fax: ____________________________

Child Care Provider: ____________________________________________

Start Date: _________________________________

Contact Person: ____________________________________________

Address: _________________________________________________

__________________________________________________________

Phone: ___________________ Fax: ____________________________

Child Care Provider: ____________________________________________

Start Date: _________________________________

Contact Person: ____________________________________________

Address: _________________________________________________

__________________________________________________________

Phone: ___________________ Fax: ____________________________
Respite Care
Community Health Care / Service Providers

- Respite Care Provider: ____________________________________________________________
  Start Date: ___________________________________________________
  Contact Person: ________________________________________________
  Agency: _____________________________________________________________
  Address: _____________________________________________________________
  _________________________________________________________________
  Phone: ___________________________ Fax: ___________________________

- Respite Care Provider: ____________________________________________________________
  Start Date: ___________________________________________________
  Contact Person: ________________________________________________
  Agency: _____________________________________________________________
  Address: _____________________________________________________________
  _________________________________________________________________
  Phone: ___________________________ Fax: ___________________________

- Respite Care Provider: ____________________________________________________________
  Start Date: ___________________________________________________
  Contact Person: ________________________________________________
  Agency: _____________________________________________________________
  Address: _____________________________________________________________
  _________________________________________________________________
  Phone: ___________________________ Fax: ___________________________
<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Contact Person</th>
<th>Address</th>
<th>Phone</th>
<th>Fax</th>
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<tbody>
<tr>
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</tr>
</tbody>
</table>
Special Transportation
Community Health Care / Service Providers

• Transportation (to and from medical / therapy appointments)

  Contact Person: ____________________________________________
  Agency: ____________________________________________
  Address: ____________________________________________
  ______________________________________________________
  Phone: __________________ Fax: __________________

• Transportation (to and from medical / therapy appointments)

  Contact Person: ____________________________________________
  Agency: ____________________________________________
  Address: ____________________________________________
  ______________________________________________________
  Phone: __________________ Fax: __________________
### Alphabet Soup

**Acronym Index**

The following index lists a wide variety of acronyms used by professionals who work with families.

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCH</td>
<td>Association for the Care of Children’s Health</td>
</tr>
<tr>
<td>ADA</td>
<td>Americans with Disabilities Act</td>
</tr>
<tr>
<td>ADD</td>
<td>Attention Deficit Disorder</td>
</tr>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
</tr>
<tr>
<td>AFDC</td>
<td>Aid to Families with Dependent Children</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ARC</td>
<td>The Arc: Advocates for the Rights of Citizens with Developmental Disabilities and their families</td>
</tr>
<tr>
<td>ARNP</td>
<td>Advanced Registered Nurse Practitioner</td>
</tr>
<tr>
<td>BIA</td>
<td>Bureau of Indian Affairs</td>
</tr>
<tr>
<td>BD</td>
<td>Behaviorally Disabled</td>
</tr>
<tr>
<td>CAP</td>
<td>Community Alternative Program (Medicaid), Community Action Program (Dept. of Community Development), Client Assistance Program (Division of Vocational Rehabilitation)</td>
</tr>
<tr>
<td>CD</td>
<td>Communication Disorders</td>
</tr>
<tr>
<td>CDS</td>
<td>Communication Disorders Specialist</td>
</tr>
<tr>
<td>CEC</td>
<td>Council for Exceptional Children</td>
</tr>
<tr>
<td>CFR</td>
<td>Code of Federal Regulations</td>
</tr>
<tr>
<td>CHAP</td>
<td>Children Have a Potential (Air Force assistance program)</td>
</tr>
<tr>
<td>CHDD</td>
<td>Center on Human Development and Disability at the University of Washington</td>
</tr>
<tr>
<td>CHRMC</td>
<td>Children's Hospital and Regional Medical Center</td>
</tr>
<tr>
<td>CP</td>
<td>Cerebral Palsy</td>
</tr>
<tr>
<td>CPS</td>
<td>Child Protective Services</td>
</tr>
<tr>
<td>CSHCN</td>
<td>Children with Special Health Care Needs</td>
</tr>
<tr>
<td>CSO</td>
<td>Community Service Office, DSHS</td>
</tr>
<tr>
<td>DCD</td>
<td>Department of Community Development</td>
</tr>
<tr>
<td>DCFS</td>
<td>Division of Children and Family Services</td>
</tr>
<tr>
<td>DD</td>
<td>Developmentally Disabled</td>
</tr>
<tr>
<td>DDD</td>
<td>Division of Developmental Disabilities, DSHS</td>
</tr>
<tr>
<td>DDPC</td>
<td>Developmental Disabilities Planning Council</td>
</tr>
<tr>
<td>DH</td>
<td>Developmentally Handicapped</td>
</tr>
<tr>
<td>DMH</td>
<td>Division of Mental Health</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DSB</td>
<td>Department of Services for the Blind</td>
</tr>
<tr>
<td>DSHS</td>
<td>Department of Social and Health Services</td>
</tr>
<tr>
<td>DVR</td>
<td>Division of Vocational Rehabilitation</td>
</tr>
<tr>
<td>ECDAW</td>
<td>Early Childhood Development Association of Washington</td>
</tr>
<tr>
<td>ECEAP</td>
<td>Early Childhood Education and Assistance Program</td>
</tr>
<tr>
<td>ED</td>
<td>Emotionally Disturbed</td>
</tr>
<tr>
<td>EEG</td>
<td>Electroencephalogram</td>
</tr>
<tr>
<td>EEU</td>
<td>Experimental Education Unit, CHDD</td>
</tr>
<tr>
<td>EFMP</td>
<td>Exceptional Family Member Program (helps military families locate to areas with services)</td>
</tr>
<tr>
<td>EKG</td>
<td>Electrocardiogram</td>
</tr>
<tr>
<td>EPSDT</td>
<td>Early Periodic Screening, Diagnosis, and Treatment</td>
</tr>
<tr>
<td>ESD</td>
<td>Educational Service District</td>
</tr>
<tr>
<td>FAPE</td>
<td>Free Appropriate Public Education</td>
</tr>
<tr>
<td>FRC</td>
<td>Family Resources Coordinator</td>
</tr>
<tr>
<td>HHS</td>
<td>Health and Human Services</td>
</tr>
<tr>
<td>HI</td>
<td>Health Impaired or Hearing Impaired</td>
</tr>
<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
</tr>
<tr>
<td>HO</td>
<td>Healthy Options, DSHS, Medicaid Managed Care Program</td>
</tr>
<tr>
<td>HOH</td>
<td>Hard of Hearing</td>
</tr>
<tr>
<td>ICC</td>
<td>Interagency Coordinating Council; county ICC and state ICC.</td>
</tr>
<tr>
<td>IDEA</td>
<td>Individuals with Disabilities Education Act</td>
</tr>
<tr>
<td>IEP</td>
<td>Individual Education Plan</td>
</tr>
<tr>
<td>IFSP</td>
<td>Individual Family Service Plan</td>
</tr>
</tbody>
</table>

(continued)
## Alphabet Soup

### Acronym Index

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I &amp; R</td>
<td>Information and Referral</td>
</tr>
<tr>
<td>ISP</td>
<td>Individual Service Plan</td>
</tr>
<tr>
<td>LD</td>
<td>Learning Disabled</td>
</tr>
<tr>
<td>LDA</td>
<td>Learning Disabilities Association</td>
</tr>
<tr>
<td>LEA</td>
<td>Local Education Agency</td>
</tr>
<tr>
<td>LICWAC</td>
<td>Local Indian Child Welfare Advocacy Board</td>
</tr>
<tr>
<td>LRE</td>
<td>Least Restrictive Environment</td>
</tr>
<tr>
<td>MAA</td>
<td>Medical Assistance Administration</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MD</td>
<td>Medical Doctor</td>
</tr>
<tr>
<td>MDT</td>
<td>Multi-Disciplinary Team</td>
</tr>
<tr>
<td>MH</td>
<td>Multiply Handicapped</td>
</tr>
<tr>
<td>MR</td>
<td>Mentally Retarded</td>
</tr>
<tr>
<td>MS</td>
<td>Multiple Sclerosis</td>
</tr>
<tr>
<td>NICU</td>
<td>Neonatal Intensive Care Unit</td>
</tr>
<tr>
<td>OCR</td>
<td>Office of Civil Rights</td>
</tr>
<tr>
<td>OFM</td>
<td>Office of Financial Management</td>
</tr>
<tr>
<td>OI</td>
<td>Orthopedically Impaired</td>
</tr>
<tr>
<td>OSEP</td>
<td>Office of Special Education Programs</td>
</tr>
<tr>
<td>OSERS</td>
<td>Office of Special Education and Rehabilitation Services</td>
</tr>
<tr>
<td>OSPI</td>
<td>Office of Superintendent of Public Instruction</td>
</tr>
<tr>
<td>OT</td>
<td>Occupational Therapy/Therapist</td>
</tr>
<tr>
<td>OTR</td>
<td>Licensed and Registered Occupational Therapist</td>
</tr>
<tr>
<td>PAVE</td>
<td>Parents Are Vital in Education</td>
</tr>
<tr>
<td>P &amp; A</td>
<td>Protection and Advocacy</td>
</tr>
<tr>
<td>PFTH</td>
<td>Program for the Handicapped (military program)</td>
</tr>
<tr>
<td>PHN</td>
<td>Public Health Nurse</td>
</tr>
<tr>
<td>PL</td>
<td>Public Law</td>
</tr>
<tr>
<td>PT</td>
<td>Physical Therapy/Therapist</td>
</tr>
<tr>
<td>PTA</td>
<td>Parent Teacher Association</td>
</tr>
<tr>
<td>RCW</td>
<td>Revised Code of Washington (state law)</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>RPT</td>
<td>Registered Physical Therapist</td>
</tr>
<tr>
<td>SBD</td>
<td>Seriously Behaviorally Disabled</td>
</tr>
<tr>
<td>SEA</td>
<td>State Education Agency</td>
</tr>
<tr>
<td>SEAC</td>
<td>Special Education Advisory Council</td>
</tr>
<tr>
<td>SEPAC</td>
<td>Special Education Parent/Professional Advisory Council</td>
</tr>
<tr>
<td>SLD</td>
<td>Specific Learning Disability</td>
</tr>
<tr>
<td>SSA</td>
<td>Social Security Administration</td>
</tr>
<tr>
<td>SSI</td>
<td>Social Security Income</td>
</tr>
<tr>
<td>STOMP</td>
<td>Specialized Training of Military Parents</td>
</tr>
<tr>
<td>SW</td>
<td>Social Work/Worker</td>
</tr>
<tr>
<td>TAPP</td>
<td>Technical Assistance for Parents and Professionals</td>
</tr>
<tr>
<td>TASH</td>
<td>The Association for Persons with Severe Handicaps</td>
</tr>
<tr>
<td>TBI</td>
<td>Traumatic Brain Injury</td>
</tr>
<tr>
<td>TDD</td>
<td>Telecommunication Device for the Deaf</td>
</tr>
<tr>
<td>TTY</td>
<td>Telecommunication Device for Deaf, Hearing Impaired, and Speech Impaired Persons</td>
</tr>
<tr>
<td>VI</td>
<td>Visually Impaired</td>
</tr>
<tr>
<td>WAC</td>
<td>Washington Administrative Code</td>
</tr>
<tr>
<td>WACD</td>
<td>Washington Association for Citizens with Disabilities</td>
</tr>
<tr>
<td>WIC</td>
<td>Women, Infants and Children Supplemental Food Program</td>
</tr>
<tr>
<td>WSMC</td>
<td>Washington State Migrant Council</td>
</tr>
<tr>
<td>WSSB</td>
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This list was adapted from and used with permission of PAVE.
# Medical / Surgical Highlights

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## Lab Work / Tests / Procedures

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Equipment / Supplies

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  Description (brand name, size, etc.): ________________________________
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  Contact Person: ___________________________ Phone: __________________

- Name of Equipment: ________________________________________________
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CARE NOTEBOOK
CHILDREN’S HOSPITAL AND REGIONAL MEDICAL CENTER, SEATTLE, WASHINGTON
WASHINGTON STATE DEPARTMENT OF HEALTH,
CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM
# Appointment Log

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Care Summary: Activities of Daily Living

Use this page to talk about your child's abilities to feed him or herself, bathe, get dressed, use the bathroom, comb hair, brush teeth, etc. Describe what your child can do by him or herself and any help or equipment your child uses for these activities. Describe any special routines your child has for bathtime, getting dressed, etc.

Date: ______________________________
Care Summary: Nutrition

Use this page to talk about your child's nutritional needs. Describe foods and any nutritional formulas your child takes, any food allergies or restrictions, and any special feeding techniques, precautions, or equipment used for feedings. Describe any special mealtime routines your family and child have.

Date: ______________________________
Care Summary:
Respiratory

Use this page to talk about your child's respiratory care needs. Describe the care or treatments your child needs and any special techniques or precautions you use when giving care. Include any special routines your child has for respiratory care.

Date: ______________________________
Care Summary: Communication

Use this page to talk about your child's ability to communicate and to understand others. Describe how your child communicates. Include sign language words, gestures, or any equipment or help your child uses to communicate or understand others. Include any special words your family and child use to describe things.

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Care Summary: Mobility

Use this page to talk about your child's ability to get around. Describe how your child gets around. Include what your child can do by him or herself and any help or equipment your child uses to get around. Describe any activity limits and any special routines your child has for transfers, pressure releases, positioning, etc.

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CARE NOTEBOOK
CHILDREN’S HOSPITAL AND REGIONAL MEDICAL CENTER, SEATTLE, WASHINGTON
WASHINGTON STATE DEPARTMENT OF HEALTH, CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM
Care Summary:  
Rest / Sleep

Use this page to talk about your child's ability to get to sleep and to sleep through the night. Describe your child's bedtime routine and any security or comfort objects your child uses.

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Care Summary: 
Social / Play

Use this page to talk about your child's ability to get along with others. Describe how your child shows affection, shares feelings, or plays with other children. Describe what works best to help your child get along or cooperate with others. Describe your child's favorite things to do. Include any special family activities or customs that are important.

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Care Summary: 
Coping / Stress Tolerance

Use this page to talk about how your child copes with stress. Stressful events might include new people or situations, a hospital stay, or procedures such as having blood drawn. Describe what things upset your child and what your child does when upset or when he or she has “had enough”. Describe your child’s way of asking for help and things to do or say to comfort your child.

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Care Summary:
Transitions—Looking Ahead

Your child and family will experience many transitions, small and large, over the years. Three predictable transitions occur: when your child reaches school age, when he or she approaches adolescence, and when your child moves from adolescence into adulthood. Other transitions may involve moving into new programs, working with new agencies and care providers, or making new friends. Transitions involve changes: adding new expectations, responsibilities, or resources, and letting go of others.

It’s not always easy to think about the future. There may be many things, including what has to be done today, that keep you from looking ahead. It may be helpful to take some time to jot down a few ideas about your child’s and family’s future. You might start by thinking about your child’s and family’s strengths. How can these strengths help you plan for “what’s next” and for reaching long term goals? What are your dreams and your fears about your child’s and family’s future?

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Developed in partnership with staff from the Adolescent Health and Transition Project
Care Summary:
Child’s Page—Now and Later

Use this page for your child’s words and thoughts about his or her life now as well as later. What are your child’s dreams? What does he or she do well now that might give direction for life later? What does your child want to be when he or she grows up?

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Developed in partnership with staff from the Adolescent Health and Transition Project
### Medical Bill Tracking Form

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### Medications

**Allergies:**

**Pharmacy:** ____________________________ **Phone:** ____________________________

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