The Snappy Finder
By
Snap4kids

My Personal History

Name:____

What I Liked to be Called:_______________________________________

My Caregivers:____

Please call me:_______________________ or ____________________________

Date of Birth:___________________ Social Security #:________-____-________

Where copy of birth certificate is located:

____

Where copy of Social Security card is located:

____

Home Address:____

Phone#:______________________________ Fax#:________________________________

Emergency Contact:____

Allergies:____

____

Insurance Information

(Please note all insurance providers)

Company_________________________________ID#_________________________

Group #_______________________ Subscriber:_____________________________

Case manager:_____________________________ ph.#________________________

Company_________________________________ID#_________________________

Group #_______________________ Subscriber:_____________________________

Case manager:_____________________________ ph.#________________________

Company_________________________________ID#_________________________

Company_________________________________ID#_________________________

Group #_______________________ Subscriber:_____________________________

Other:____

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Family Medical History

Family Health (Check where appropriate and note relationship to your child)

Cardiac	Hypertension	Renal
Tuberculosis	GI	Cancer
Allergy	Ortho	Lung
Diabetes	Blood	Ear
Thyroid	Vision	Neuro
Development	Psych	Auto Immune

Parents:

Father's Health____

Mother's Health____

Brothers and Sisters:

Name	Date Of Birth	Health

WHEN I WAS BORN:

(birth history, pregnancy, location, complications, neonatal hospitaliztion)

____

____

____

____

____

____

____

____

My Diagnosis

Date/Year	Diagnosis

Surgeries that I have had:

Date/Year	Surgery

Surgery Comments

My Primary Care Physician

My Immunization Record

DtaP	1.	2.	3.	4.	5.
DT	1.	2.			
Polio	1.	2.	3.	4.	
HIB	1.	2.	3.	4.	
Prevnar	1.	2.	3.	4.	
MMR	1.	2.			
Varicella	1.				
HBV	1.	2.	3.		
TB					
Flu					
Other					
Other					

Name:____ Specialty______________________

Phone#:__________________________Fax#___________________________

Address:____

All My Doctors

Name:____ Specialty_______________________

Phone#:___________________________Fax#____________________________

Address:____

Name:____ Specialty_______________________

Phone#:___________________________Fax#____________________________

Address:____

Name:____ Specialty_______________________

Phone#:___________________________Fax#____________________________

Address:____

Name:____ Specialty_______________________

Phone#:___________________________Fax#____________________________

Address:____

Name:____ Specialty_______________________

Phone#:___________________________Fax#____________________________

Address:____

Name:____ Specialty_______________________

Phone#:___________________________Fax#____________________________

Address:____

My nursing agency:

Name:________________________Phone:_______________Contact:______________

# of hours approved:_______ Day:_____________ Night:__________ Wknd:________

Medication Information

My pharmacies:

(Include mail order pharmacies and prescripton assistance programs)

Name:________________________________ Phone:___________________________

Name:________________________________ Phone:___________________________

Name:________________________________ Phone:___________________________

Name:________________________________ Phone:___________________________

Medications:

Medication Name____

Directions____

Pharmacy Name & Phone____

Prescribing Doctor & Phone____

Medication Name____

Directions____

Pharmacy Name & Phone____

Prescribing Doctor & Phone____

Medication Name____

Directions____

Pharmacy Name & Phone____

Prescribing Doctor & Phone____

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Pharmacy Name & Phone____

Prescribing Doctor & Phone____

Medication Name____

Directions____

Pharmacy Name & Phone____

Prescribing Doctor & Phone____

Medication Name____

Directions____

Pharmacy Name & Phone____

Prescribing Doctor & Phone____

My Medication Tracking Sheet

Start Date	Medication (brand/generic)	Concentration	Dose	Freq.	D/C

Medical Equipment & Supplies

Medical Equipment Own/Use

Name of Equipment____

Prescribed By_____________________________________

Reason Prescribed____

Supplied By_______________________________________

Name of Equipment____

Prescribed By_____________________________________

Reason Prescribed____

Supplied By_______________________________________

Name of Equipment____

Prescribed By_____________________________________

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Name of Equipment____

Prescribed By____________________________________

Reason Prescribed____

Supplied By_______________________________________

Name of Equipment____

Prescribed By____________________________________

Reason Prescribed____

Supplied By_______________________________________

Equipment Notes, Problems, and Concerns:_________________________________

Therapies

My Outpatient Therapies:

Therapy:________________Frequency:____

Therapist:_______________________________________Phone#:____________________

Location:____

Therapy:________________Frequency:____

Therapist:_______________________________________Phone#:____________________

Location:____

Therapy:________________Frequency:____

Therapist:_______________________________________Phone#:____________________

Location:____

Therapy:________________Frequency:____

Therapist:_______________________________________Phone#:____________________

Location:____

Therapy:________________Frequency:____

Therapist:_______________________________________Phone#:____________________

Location:____

Therapy:________________Frequency:____

Therapist:_______________________________________Phone#:____________________

Location:____

My School Therapies:

Therapy:________________Frequency:____

Therapist:_______________________________________Phone#:____________________

Therapy:________________Frequency:____

Therapist:_______________________________________Phone#:____________________

Therapy:________________Frequency:____

Therapist:_______________________________________Phone#:____________________

Addditional Information on School Related Therapies:___________________________

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My Doctor Visits

My Doctor Visits/Tests/Procedures
Tracking Sheet

Date	Seen by	Changes Made/Updates

Date	Seen by	Changes Made/Updates

My Daily Care

My Daily Medical Treatments

My Daily Treatments
(i.e. respiratory treatment, O_2, vent, trach, g-tube, etc.)
If you have a Plan of Care, please insert copy here

Vital Signs: (Freq.)____

____

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____

Adaptive Equipment:(W/C, braces, splints, speech devices)__________________

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____

Respiratory Tx (O_2, trach, vent, etc.)__________________________________

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____

Trach/G-tube/other care:____

____

Bowel/Bladder Regime:

Other:

Other:

Nutrition Facts

Nutrition Notes:

Foods I like:____

____

____

____

____

____

Favorite Restaurants and what your child enjoys eating there:

____

____

____

Foods I don't like:____

____

____

____

Food Allergies:

Food______________________________ Reaction____________________________________

Food______________________________ Reaction____________________________________

Food______________________________ Reaction____________________________________

Current diet:____

____

____

____

____

Total intake/day: ____

____

____

Total water/day: ____

____

____

I take my food by:
☐ Mouth ☐ G-tube ☐ GJ tube ☐ NG ☐ NJ Size of tube:____________________

The way my child communicates to help you understand what he/she wants. (Example: picture book or communication board)

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Watch Me Grow

Date	Weight	Height	Head Circumference

Personal Care & Hygiene

Things that are done independently
(Example: brushes teeth)

Things that need assistance
(Example: bathes, but needs help regulating running water)

Other information that would be helpful
(Example: shoe and clothing size, menstrual cycle)

Behavior Management

What consistent approach has worked best in your absence during difficult transition periods? List typical interventions that have worked in certain situations. Provide name and description of techniques or things that are helpful and where they can be located. (Example: afraid of thunderstorms, use Walkman headphones to help block out the noise)

Things that help to calm me and when they should be used

Values

List your views about dating, sex, birth control and religion

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Church Affiliation/Religious Preference_________________________________

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Sacraments/Program levels attained____________________________________

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More About Me

Activities I like to do

Things that can upset me/ things that I do not like to do

Any other important information

Describe A Typical Day For Your Child

Use as many pages as you need to describe it and don't forget likes and dislikes, mealtime and bathing and grooming.

Education/Employment Opportunities

School History

Year	School	Teacher	School Nurse	Phone#

Education/Employment Opportunities:
Please attach copy of IEP or IHP or IFSP

I go to school at:_______________________________ Phone#:_________________

Teacher:_________________________ School Nurse:________________________

School OT:____________________ Phone #:__________ Frequency:____________

School PT:____________________ Phone #:__________ Frequency:____________

School ST:____________________ Phone #:__________ Frequency:____________

What is your child's work potential and employment history? What kinds of support does he/she receive and from which agencies?

Current Place of Employment____

Contact Person____

Address____

Phone Number______________________________

Hours/Days worked____

Previous Employment

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What are your child's capabilities and skill levels? What other opportunities would like to see happen?

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Social Experiences

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/Activites 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

____

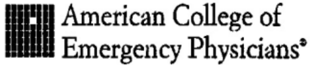
____

____

Emergency Plan

Emergency Information Form for Children With Special Needs

Last name:



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

*Consent for release of this form to health care providers

Last name:

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:

Allergies: Medications/Foods to be avoided	**and why:**
1.	
2.	
3.	

Procedures to be avoided	**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:**

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Estate / Future Planning

Letter of Intent

No one lives forever, not even parents of children with disabilities. Fears about what will happen to your child after you're gone keep you from doing the very thing that will give you peace of mind: Planning. You fear that your child's quality of life may not be the same as they have now. You also know that it should not be left totally up to their sister or brother to care for them. Sometimes the thought of all of this is so overwhelming that you don't even know where to start.

This section is that starting place. It can be a way to facilitate discussion among your family members or just a way to begin organizing your own thoughts and getting them down on paper. You can begin with the less emotional section like the Personal Information before moving on to the more difficult task of choosing a Guardian. Guardianship guidelines vary from state to state. Your attorney can advise you, but not all attorneys are familiar with Special Needs Trusts. A list of attorneys who specialize in this area may be obtained through the national, state or local Arc. Update the plan annually; birthdays are a good time to do this. Don't forget to make copies and give them to all those who should know about your wishes. Planning is a process that takes time, but once you have things decided you will be able to breathe that sigh of relief knowing you no longer have to worry about the future.

Parent/Caregiver Signature___________________________________Date________________

Parent/Caregiver Signature___________________________________Date________________

Notary Information: (Usually your bank, if you are a customer, can notarize this for you, for free.)

Family Information

Mother's Name______________________________
Maiden Name_______________________________
Social Security Number_____________________
Address____
Phone Number______________________________

Father's Name______________________________
Social Security Number_____________________
Address____
Phone Number______________________________

Sibling(s)
Name______________________________________
Spouse_____________________________________
Address____
Phone Number______________________________

Name______________________________________
Spouse_____________________________________
Address____
Phone Number______________________________

Name______________________________________
Spouse_____________________________________
Address____
Phone Number______________________________

Name______________________________________
Spouse_____________________________________
Address____
Phone Number______________________________

Name______________________________________
Spouse_____________________________________
Address____
Phone Number______________________________

Name______________________________________
Spouse_____________________________________
Address____
Phone Number______________________________

Names & Addresses of Other Relatives

And whether they have been notified that you have established a Trust so that if they want to leave money to your child/sibling, to leave it to the Trust.

Name____
Address____
Phone Number____
Notified ☐ yes ☐ no Date notified

Name____
Address____
Phone Number____
Notified ☐ yes ☐ no Date notified

Name____
Address____
Phone Number____
Notified ☐ yes ☐ no Date notified

Name____
Address____
Phone Number____
Notified ☐ yes ☐ no Date notified

Name____
Address____
Phone Number____
Notified ☐ yes ☐ no Date notified

Name____
Address____
Phone Number____
Notified ☐ yes ☐ no Date notified

Name____
Address____
Phone Number____
Notified ☐ yes ☐ no Date notified

List of individuals, advocates and/or service providers who touch the life of my child/sibling.

Name____
Address____
Phone Number____
What they typically do with/for my child/sibling
____
____
____

Name____
Address____
Phone Number____
What they typically do with/for my child/sibling
____
____
____

Name____
Address____
Phone Number____
What they typically do with/for my child/sibling
____
____
____

Name____
Address____
Phone Number____
What they typically do with/for my child/sibling
____
____
____

Living Arrangements

Where and in what type of situation would you like to see your child live? Would they live alone or have roommates? What neighborhood? How much supervision would they need?

____

____

____

____

____

If currently in a supported living environment, list the following information:

Home Manager
Name and Phone Number____

Case Manager
Name and Phone Number ____

First Choice of Future Residential Provider

____

Second Choice____

Other Service Agencies

(Example: Family Resources, Transportation, etc.)

Agency Name____
Contact Person____
Phone Number____
Reason Used____

Agency Name____
Contact Person____
Phone Number____
Reason Used____

Legal / Financial Information

Government/Private Benefits/Assistance
(Example: SSI, Social Security/Disability Insurance)

Type of Benefit____

Amount____

Contact Person/Case Worker____

Department of Human Services Case Worker and Phone Number:

____

Type of Benefit____

Amount____

Other Benefits (currently receiving)
(Example: transportation, cash subsidies/vouchers, utility subsidies)

____

____

Other Benefits your child might be entitled to upon your death (Example: Veterans, Railroad)

____

BANK_________________________ Branch Location__________________________

Checking Account Number____

Safe Deposit box____

Savings Account Number____

LIFE INSURANCE

Company____

Policy number____

BURIAL POLICY

Funeral Home____

Cemetery____

Will & Estate Plans

Letters of Guardianship have been approved by:

Judge____ Date________________

Approved Guardian's Name____

Address____

Phone

Number____________________Relationship________________________________

Approved Successor Guardians

Name____

Address____

Phone

Number__________________Relationship__________________________________

Name____

Address____

Phone Number____________Relationship_________________________________

If a guardian has not been appointed, list in order of preference the people who you would like to serve as guardian, should guardianship prove necessary in the future. Include name(s), address, phone number and the person's relationship to you.

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Questions / Concerns / Notes / Additional Information

Questions:

Concerns:

Notes:

Additional Information:

The End