ASSORTED SAMPLE FORMS

You can pick and choose from these forms or use them as templates to make your own.

1) Family History
2) Medication & Supplement Log
3) Daily Medication Administration Log
4) Side Effects
5) Hospitalizations & Surgeries
6) Personal Information & Daily Schedule Forms for Temporary Care Providers
7) ER Form, courtesy of American College of Emergency Physicians & American Academy of Pediatrics

Updated to Web - Jan 2012

FAMILY HISTORY

Courtesy of Jean Miller

Family History
(consider neurological disease, heart disease, diabetes, cancer, migraines, etc.)

Father Living ( ) Yes ( ) No Age at death ____

Medical conditions and/or cause of death _____

Mother Living ( ) Yes ( ) No Age at death ____

Medical conditions and/or cause of death _____

Spouse Living ( ) Yes ( ) No Age at death ____

Medical conditions and/or cause of death _____

Brother(s) Living ( ) Yes ( ) No Age at death ____

Medical conditions and/or cause of death _____

Sister(s) Living ( ) Yes ( ) No Age at death ____

Medical conditions and/or cause of death _____

Paternal-Grandfather Living ( ) Yes ( ) No Age at death ____

Medical conditions and/or cause of death _____

Paternal-Grandmother Living ( ) Yes ( ) No Age at death ____

Medical conditions and/or cause of death _____

Maternal-Grandfather Living ( ) Yes ( ) No Age at death ____

Medical conditions and/or cause of death _____

Maternal-Grandmother Living ( ) Yes ( ) No Age at death ____

Medical conditions and/or cause of death _____

Identify any Uncles and Aunts with medical conditions/identify condition:

_____

_____

_____

UMDF Note: Gaining an understanding of family history can be an important part of understanding any disease with possible genetic influence.
You can search your family tree at www.familysearch.org. In addition, you can download their Personal Ancestral File database for free and set up your own family tree.

MEDICATION & SUPPLEMENT LOG

Name:

Prescription Date	Medication Name	Doctor	Dosage	Times per day	With Food? Y/N	What It's For	Reactions & Side Effects

DAILY MEDICATION ADMINISTRATION LOG

Name: **Medication:**

Date Given	Dose	Time	Administered By:	Side Effects Noted	Why It Was Given if It Is an "As Needed" Medication

SIDE EFFECTS

Name: **Medication:**

Side Effect	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Nausea and/or Vomiting							
Drowsiness							
Fatigue							
Sore/Dry Mouth							
Itching/ Rash							
Constipation Or Diarrhea							
Other							

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HOSPITALIZATIONS & SURGERIES

Name: **Date of Birth:**

Reason for Hospitalization:	Date

Reason for Surgery:	Date

Allergies:

Personal Information &

Daily Schedule Forms

For Temporary Care Providers

Prepared By:
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SPECIAL CARE INSTRUCTIONS FOR

_____

Personality Traits

General description

Describe what living with he/she is like, any unusual habits or traits requiring special attention.

_____

_____

_____

_____

_____

Basic Characteristics & Personality

Provide overall description of personality and describe any unique characteristics, which would help the caretaker understand any special needs

_____

_____

_____

_____

_____

Abilities & Skills

Describe what they can do alone, things they may need assistance with etc.. Things such as walking, using bathroom, eating, handling controls for TV, using phone, etc.

Able To Do Without Assistance: _____

_____

_____

Needs some assistance**:** _____

_____

_____

Needs full assistance: _____

_____

_____

Other (describe things they may get upset if you try to do for them):

_____

Physical Abilities

Communication Skills

Describe any problems with communication, special signals used, storyboards or any devices used to help them communicate.

Physical Mobility

Describe in detail any special requirements where assistance may be needed like getting up from a sitting/laying position, wheelchair, toilet, walking, etc. and how the person feels most comfortable getting assistance (i.e. hold from behind; lift from front until stable on feet, etc.)

Hearing Ability

Do they wear a hearing aid? Does volume of TV/radio need to be at a special level? Is there any sensitivity to loud noises? What, if anything, should be avoided?

Seeing Ability

Do they wear glasses, if so what are they needed for? (Reading, TV, walking, etc.)

Special Considerations:

Do they have a movement disorder where special consideration is needed? Are things such as special utensils or wrist weights, etc. utilized?

CLOTHING

Favorite type of clothing

Are there any clothes they prefer? Any to be avoided?

_____

_____

Favorite Colors and Patterns

Self-explanatory. I.e. if they like to wear pink or blue all the time, indicate.

_____

_____

Special Considerations

Are they hot or cold all of the time? Do they like to go barefoot? Wear shorts all the time? Prefer to wear little or no clothing? Describe any special considerations needed:

_____

_____

_____

SPECIAL PLACES

Favorite Setting

Is there a favorite spot in the house they would prefer being in during different times of the day? A special chair? Are there areas that should be avoided? Why?

Mornings: _____

Afternoon_____

Evenings: _____

Nap time: _____

Bedtime: _____

Meals: _____

Other: _____

Favorite Places/Places they like to go

Do they like to take a walk daily? Have coffee with a neighbor? Go to the movies? Indicate where the caretaker may take them in your absence.

_____

_____

_____

Entertainment Preferred

Describe what they enjoy doing the most in their daily routine. Do they like having a book or newspaper read to them? Listen to a favorite tape, radio or TV station? Are there games they enjoy playing alone or with someone?

_____

_____

_____

Recreation

Are there daily or weekly schedules of outings? Do they enjoy being taken to a nearby park? Will someone be taking them to a movie, etc..

_____

_____

_____

Habits & Hygiene

Personal Habits

Describe any personal traits the caretaker should be aware of: for example if the person hates bathing, changing clothes, changes clothes frequently, or has any compulsive tendencies

_____

_____

_____

Grooming (see Daily Schedules below)

Indicate how much assistance is required and normal daily schedule for each.

Dental Care _____

Bathing _____

Shaving _____

Hair Care_____

Toileting _____

Personal Care _____

Dressing _____

Other/Additional Details: _____

_____

_____

_____

Cleanliness and Neatness

Indicate personal habits, areas of difficulty, special needs for protective clothing etc.

_____

_____

_____

_____

Bathroom

Describe any special needs that should be considered. What is their level of urgency, i.e. should they be taken immediately to a restroom when they indicate they need to relieve themselves? Are they incontinent? If yes, what special things need to be considered?

Bathing

Do they need assistance? Prefer shower or tub? Any special equipment, like a tub chair required? Do they have any preference for soaps or shampoos? Do they like to linger or get it over with quickly? What is their level of modesty, what might embarrass them?

PERSONAL PREFERENCES

Foods

List any favorite foods

Eating Habits

Describe things like whether snacks are allowed, how often, types? Any precautions to be taken with monitoring them while eating, special utensils, etc.

Special Food Considerations

Describe foods to be avoided for swallowing considerations, gas, etc., whether meals should be prepared in a certain way (cut into small pieces, pureed, soft-foods, thickeners added, etc.)

Drinks

Describe liquids to be avoided, whether thickeners need to be added, favorite drinks, etc. If there are special recipes or prepared drinks identify them.

_____

_____

_____

Sleeping Habits

What are their normal sleeping schedules? Should they be kept awake certain hours? What clothing do they prefer to sleep in? Do they prefer sleeping on their side or back? Is it okay for them to sleep on couch or other area?

_____

_____

_____

Hobbies & Interests

Describe/let caretaker knows if there are items around the house reflecting the person's hobby/interest that could be brought out and talked about. Do they participate in a hobby on a regular basis, etc?

_____
_____
_____
_____

Social Support

Are there special people in their life who they may want to talk with or have visit? Who is allowed to visit in your absence? Who is not?

Name _____ Phone _____
Address_____
_____
City State Zip
Who they are: _____
They are: ___ Allowed To Visit Anytime ___ Must Call First __ Must Wait Until You Return

Name _____ Phone _____
Address_____
_____
City State Zip
Who they are: _____
They are: ___ Allowed To Visit Anytime ___ Must Call First __ Must Wait Until You Return

Name _____ Phone _____
Address_____
_____
City State Zip
Who they are: _____
They are: ___ Allowed To Visit Anytime ___ Must Call First __ Must Wait Until You Return

OTHER CONSIDERATIONS

Identify all other things the caretaker should be aware of in your absence. Make sure they know where a copy of the EMERGENCY INFORMATION & DAILY MEDICATION SHEETS are that lists all critical contacts, phone numbers, etc. and provide specific medical information on your loved one. (Post them on the refrigerator)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

APPOINTMENTS

List all appointments that may be scheduled for your loved one during your absence that couldn't be changed. Do they go for therapy weekly? A day care facility? Is someone scheduled to come take them someplace? Are aids or nurses scheduled to visit?

Indicate whether the caretaker must provide transportation. If special transportation is required (i.e. non-emergency transport vehicle) make arrangements with that provider in advance, leave number for caretaker to verify pick up day before, etc.

Date	Time	Purpose	Contact/Phone	Directions

Added by UMDF:

Questions to ask: (i.e., changes in treatments or condition, outcome of any new tests/procedures, new tests to be scheduled, other support services recommended, next appointment)

_____
_____
_____
_____

DAILY HYGIENE SCHEDULE

Sticking to a routine can be very important! Identify each activity that your loved one is accustomed to and any special thing the caretaker *must* consider. I.e. like using an electric toothbrush, frequency of brushing teeth, assistance with rinsing mouth/swallowing concerns, washing hair daily or every other day, once a week, etc.

Activity	**Time**(s)	**Special Considerations**
Bath/Shower		
Mouth care (toothpaste type)		
Hair Care (washing, brushing)		
Shaving/frequency		
Fingernails (cutting, filing etc)		
Toenails (cutting, filing etc)		
Body skin care		
Face care		
Lip care (balms, moistures)		
Hand or feet skin care		
Eye care (drops, etc.)		
Normal massage(s)		
Rotation in bed		
Other		
Bedding changed		
Mattress protection		
Pillows desired		
Covering desired		
Incontinence products		

DAILY MEAL & SNACK SCHEDULE

Identify normal meal and snack times. Indicate whether there are special dietary considerations for food and/or drinks. Any special cups, plates or utensils? What about wrists weights, clothing protectors or area where meal should be given?

Daily Calorie Intact Required: _____
Daily Clear Fluid Needs: _____

Meal / Snack	Time	Special Considerations

DAILY TV SCHEDULE

(Tape on side of TV)

Special Instructions:
Is it permissible for them to sleep with the TV on? Watch during meals? Is there any type of program that should be avoided (gory, horror movies, sexually explicit, etc.)

_____
_____
_____

List all regular favorite television programs and indicate level of importance i.e. whether they *must* see that particular show (i.e. caretaker is NOT to switch channels to watch another program). If there are favorite videos/movies you have that they enjoy watching add those.
If you have cable service, most have "smart boxes" where you can pre-program favorite shows to come on automatically.

Time	Show-Name	Ch #	Importance
07:00 AM			
07:30			
08:00			
08:30			
09:00			
09:30			
10:00			
10:30			
11:00			
11:30			
12:00 PM			
12:30			
01:00			
01:30			
02:00			
02:30			
03:00			
03:30			
04:00			
04:30			
05.00			
05:30			
06:00			
06:30			
07:00			
07:30			
08:00			
08:30			
09:00			
09:30			
10:00			
10:30			
11:00			
11:30			
Midnight			

INSTRUCTIONS FOR OPERATING

Microwave:

Oven:

Television (include phone number and account for cable service, TV repairman etc.)

VCR/DVD

Washer/Dryer (preference for cold water, fabric softeners, etc.)

Other items

In Case of An Emergency

Date Form Completed: _____ Current Age: _____

INFORMATION IS FOR:
Last Name: _____
First Name: _____
Middle Initial: _____
Social Security Number: _____-_____-_____
Blood Type: _____
Medications Allergic To: (See Below)

EMERGENCY PHONE NUMBERS (besides 911);
Fire: _____
Police: _____
Ambulance: _____
Hospital: _____
DIRECTIONS- To provide Emergency Personnel *directions to your home*:
Subdivision or Condo Association: _____
Nearest Intersections: _____
Nearest Major Roads : _____
OTHER PERSONAL INFORMATION
Date of Birth: _____
House Number_____
Street: _____
City_____
State_____ Zip_____
Home Phone # (____) _____ - _____
Driver's License #_____
Height: _____ Weight: _____
Hair Color: _____ Eyes: _____
Pacemaker: ( ) yes ( ) no
Eye Glasses: ( ) yes ( ) no
Contact Lens: ( ) yes ( ) no
False Teeth: ( ) yes ( ) no
Birthmarks or Scars/Where: _____

PHYSICIAN(s):
Primary Care Doctor_____
City/State: _____
Telephone Number _____
Emergency Service _____

Specialist (identify)
City/State: _____
Telephone Number _____
Emergency Service _____

HOSPITAL(s) -
Name the *preferred hospital* or one covered by your insurance

If necessary transport me to the following hospital:

_____

INSURANCE:

Primary

Carrier (i.e. Prudential etc)_____

Policy #_____Group #_____

Policy Holder's Name: _____

Phone: _____

Pre-Certification Phone: _____

Secondary (Medicaid, Medicare, etc.)

Carrier _____

Policy #_____Group #_____

Policy Holder's Name: _____

Phone: _____

Pre-Certification Phone: _____

EMERGENCY CONTACT(s)

Name _____

Relationship to you _____

Phone Number _____

Cell Phone/Pager _____

Name _____

Relationship to you _____

Phone Number _____

Cell Phone/Pager _____

OTHER PERTINENT DOCUMENTS/INFORMATION

If applicable, attach document to this sheet

Living Will ( ) yes ( ) no

Do Not Resituate ( ) yes ( ) no

Organ Donor: ( ) yes ( ) no

Medical Power of Attorney:

Person Designated:_____

Telephone Number _____

Cell Phone/Pager #_____

CHRONIC MEDICAL CONDITION(s)

(Identify, i.e. Huntington's Disease, Cancer, Congestive Heart Failure, Diabetic I or II, Emphysema, Epilepsy, Seizures, Kidney or Liver disease etc.)

Condition:_____

Diagnosed:_____

Specialist:_____

Condition:_____

Diagnosed:_____

Specialist:_____

OTHER MEDICAL CONDITIONS:
(Identify i.e. Hearing Loss, Blind, Anemia, Thyroid Disease, High Blood Pressure, etc.)

Condition:_____
Diagnosed:_____
Specialist:_____

Condition:_____
Diagnosed:_____
Specialist:_____

VACCINATIONS - Year of last vaccination
___Tetanus/diphtheria
___Pneumococcal vaccine
___Flu vaccine
___Measles, mumps, rubella
___Polio
___Varicella (chickenpox)
___Hepatitis A
___Hepatitis B

ALLERGIC TO - DO *NOT* GIVE:

(list everything i.e. Morphine causes rash, etc.)

Allergic to:_____
Reaction: _____

Allergic to:_____
Reaction: _____

Allergic to:_____
Reaction: _____

SPECIAL INSTRUCTIONS:
Identify i.e.: Keep Calm/Tends To Hyperventilate When Excited-Seizure Prone;
Do Not Use Restraints; Keep Head Elevated/Swallowing Difficulties, etc.

_____
_____
_____
_____

CURRENT PRESCRIPTION MEDICATION(s)
List or use the Medication Form and say "See Attached"

ADDITIONAL CONTACTS - (To Be Made By Family, **Not** EMS, I.e. employer, other emergency contacts, funeral homes, clergy, etc.)

Organization:_____
Person To Contact_____
Telephone No. _____

Organization:_____
Person To Contact_____
Telephone No. _____

Organization:_____
Person To Contact_____
Telephone No. _____

THIS PERSON IS UNDER AGE 18

This form is for my child, under age 18. Permission is granted to treat my child in an emergency
( ) Yes. ( ) No, contact me prior to treating.

Parent Name:_____
Emergency Telephone Number:_____

Signature:_____

Weekly Medication Directions and Check-off Chart

Name of Drug /Direction	SUN	MON	TUE	WED	THU	FRI	SAT

Weekly Medication Directions and Check-off Chart

Name of Drug /Direction	SUN	MON	TUE	WED	THU	FRI	SAT

Weekly Medication Directions and Check-off Chart

Name of Drug /Direction	SUN	MON	TUE	WED	THU	FRI	SAT

Weekly Medication Directions and Check-off Chart

Name of Drug /Direction	SUN	MON	TUE	WED	THU	FRI	SAT

Therapy Calendar

Schedule of Activities

When	
Where	
When	
Where	
When	
Where	

The name, phone number, and contact for therapist:

Therapist:
Type: **(Speech, Physical, Rehab etc.)**
Address:
Phone Number: Office Hours:

Questions and concerns to discuss with therapist **(check off when answered):**

☐	
☐	
☐	
☐	
☐	
☐	

List of recommendations made by therapist **(check off when accomplished):**

☐	
☐	
☐	
☐	
☐	
☐	

My Medication & OTC Form

Date:________________ Name:______________________
Primary Physician:________________________________
Physician Telephone: (___) ____ - _________
Pharmacy: ___________________________________
Pharmacy Telephone: (____)_____-___________
Allergies: _______________________________________

Prescribed Medications (Rx)

Drug Name ________________________/Generic Name _________________
Purpose____ Strength__________
Qty Taken Daily ________Special Directions___________________________

Drug Name ________________________/Generic Name _________________
Purpose____ Strength__________
Qty Taken Daily ________Special Directions___________________________

Drug Name ________________________/Generic Name _________________
Purpose____ Strength__________
Qty Taken Daily ________Special Directions___________________________

Drug Name ________________________/Generic Name _________________
Purpose____ Strength__________
Qty Taken Daily ________Special Directions___________________________

Drug Name ________________________/Generic Name _________________
Purpose____ Strength__________
Qty Taken Daily ________Special Directions___________________________

Drug Name ________________________/Generic Name _________________
Purpose____ Strength__________
Qty Taken Daily ________Special Directions___________________________

Drug Name ________________________/Generic Name _________________
Purpose____ Strength__________
Qty Taken Daily ________Special Directions___________________________

Drug Name ________________________/Generic Name _________________
Purpose____ Strength__________
Qty Taken Daily ________Special Directions___________________________

Over-The Counter (OTC) Products:

(Vitamins, Pain Killers, Muscle Relaxers, Cold, Sinus, etc)

Name _____/Purpose_____
Strength_____ How Many Are Taken Daily _____

Name _____/Purpose_____
Strength_____ How Many Are Taken Daily _____

Name _____/Purpose_____
Strength_____ How Many Are Taken Daily _____

Name _____/Purpose_____
Strength_____ How Many Are Taken Daily _____

Name _____/Purpose_____
Strength_____ How Many Are Taken Daily _____

Over the Counter Medication History - Check those you take and indicate how often you have a need for these products (i.e. Bayer Aspirin/daily):

Items **OTC Item** **____Frequency**

__Allergies
__Aspirin
__Caffeine
__Cold/flu
__Cough
__Constipation
__Diarrhea
__Drowsiness
__Eye or ear problems
__Headache/Migraine
__Heartburn/Stomach upset/gas
__Hemorrhoids
__Insomia
__Muscle or joint pain
__Rash/itching/dry skin/skin problems
__Restlessness/Nervous
__Sinus
__Weight Gain
__Weight Loss _____
__Other (list) _____

Weekly Medication Directions & Check-off Chart

Enter the name/direction for the drug. Under the days of the week,
write in the time you should take the medicine each day.
Each time you take the drug, simply cross out that time.

Name of Drug/Direction	Sun	Mon	Tue	Wed	Thu	Fri	Sat

Emergency Information Form for Children With Special Needs

Last name:

American College of Emergency Physicians®

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.

2.

3.

4.

Synopsis:

Baseline physical findings:

Baseline vital signs:

Baseline neurological status:

*Consent for release of this form to health care providers

Last name:

Diagnoses/Past Procedures/Physical Exam continued:

Medications:

1.

2.

3.

4.

5.

6.

Significant baseline ancillary findings (lab, x-ray, ECG):

Prostheses/Appliances/Advanced Technology Devices:

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: