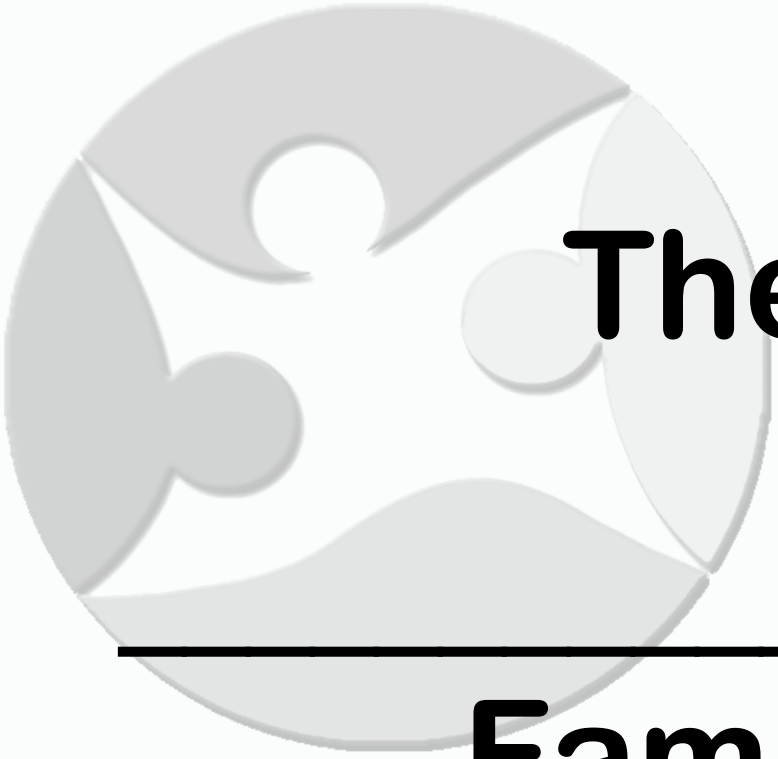

The

_____ Family

Caregiver Emergency Planner

Contacts, Need-to-Know and In-Case-of -Emergency Information

POAC Autism Services

Phone 732-785-1099 Fax 732-785-1003 www.poac.net

POAC Autism Services
Putting Awareness into Action
(732) 785-1099
www.POAC.net

Dear Parents and Caregivers,

POAC cares about the health and safety of your child. This Emergency Planner was developed in response to the concerns of those who care for and about children with autism every day. This tool has so many uses. It was originally designed as an informational guide for baby sitters and respite care providers so that parents could feel confident leaving their children in the care of others. When filled out completely, this document can be used to introduce your child to new health care providers, service providers, and to help acquaint your child with his/her teaching staff each fall.

We hope you find this planner useful.

Sincerely,
Your Friends at POAC Autism Services

Contents

**This respite planner has been adapted from The Child Neurology Foundation's "About Our Family, a Respite Workbook for Families and Care-Providers". CNF is a strong advocate for children and adolescents with neurologic and developmental disorders and can be reached at www.childneurologyfoundation.org.*

Our First Aid Kit is located:

_____

Emergency Numbers

Police and Fire: 911

Poison Control Center:_____

Parent's Work Numbers:_____

Parent's Cell Phones: _____

Emergency Contacts:

Name: _____

Number:_____

Name: _____

Number:_____

Name:_____

Number:_____

Primary Care Physician

Name:_____

Number:_____

Neurologist

Name:_____

Number:_____

Other Specialist

Name:_____

Number:_____

Closest Hospital

Name and Number:_____

Address:_____

Project Life Saver (If Applicable)

Sherriff's Phone Number_____

Transponder ID:_____

Child's Information

Child's Name:_____

Home Address:_____

Phone Number:_____

Date of Birth:_____

Social Security Number:_____

Diagnosis:_____

Allergies:_____

Favorite Toy:_____

Favorite Activity:_____

School and Address:_____

School Contact Person and Phone Number:_____

School Bus Stop:_____

School Bus Number: AM_____ PM_____

Bus Pick-up Time: AM_____ PM_____

Bus Drop-off Time: AM_____ PM_____

Child's Weekly Schedule

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00AM							
11:00AM							
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
12NOON							
1 PM							
2 PM							
3PM							
4 PM							
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
5 PM							
6 PM							
7 PM							
8 PM							

House Rules

Who, if anyone, is allowed to visit your child when you are not home?

Is your child allowed to play outside? If so, what are the boundaries?

Please describe any other house rules that are meant to be followed (use of phone, computer, tv, visitors, snacks, etc.)

Communication

Is your child verbal? Yes No

If no, how does he/she communicate?

Does your child use sign language as a form of communication? Yes No

If yes, please explain how this is done. If necessary, attach pictures or other resources to this packet.

How would your child:

Communicate the need to eat?

Ask to be picked up or held?

Express an interest in playing with a favorite toy or game?

Express general interest in what's going on?

How does your child communicate the following?

Hungry (or specific food) _____

Thirsty (or specific drink) _____

Brother _____

Sister _____

Mom _____

Dad _____

Bathroom _____

Bed _____

TV _____

Cold _____

Hot _____

Video _____

Music _____

Car _____

Outside _____

I want more _____

I am finished _____

I'm sick _____

Other words important to your child:

_____

_____

_____

_____

Is there any additional information that would help me to better understand your child's communication?

Is there any additional information that would help me to better work with your child?

Adaptive Equipment

Does your child use adaptive equipment? Yes No

If yes,

What kind of adaptive equipment is used?

When should the equipment be used?

Does your child use a specialized communication device? Yes No

If yes,

Please explain how the device is used.

Where is the equipment located and where should it be placed when not in use?

Additional Information:

Behavior

What is your child's normal temperament?

What makes your child happy?

What are your child's:
Favorite games?

Favorite toys?

Does your child run or wander away? Yes No
If yes, are there any special instructions to prevent this and where is your child likely to wander to?

Does your child have behaviors that are particularly challenging? Yes No
If yes, what are they and how do you manage them?

Do you have a specific behavior plan for your child? Please attach.

Diet

Does your child have any food allergies? If so, please explain.

What foods does your child like?

What foods does your child dislike?

What are your child's favorite foods?

Does your child swallow well? _____

Does your child chew well? _____

Does your child need assistance while eating? Yes No

If yes, what type of assistance is required?

Is there a particular position or any adaptive equipment to assist your child while eating? If yes, please explain.

Personal Hygiene

Does your child use the toilet? Yes No

Can your child use the toilet alone? Yes No
If no, what additional assistance is needed?

Does your child use:

Diapers	Yes	No
Training Pants	Yes	No
Potty Chair	Yes	No

Can your child brush his/her own teeth? Please explain how this is done.

Can your child dress him/herself? Yes No

What, if any, assistance is necessary?

Can your child bathe/shower him/herself? Yes No
If no, what additional assistance or adaptive equipment is necessary?

Additional Information:

Bed and Nap Time

When is your child's nap time?_____

When is your child's bed time?_____

Does your child generally sleep through the night?	Yes	No
Does your child sleep alone?	Yes	No
Is your child afraid of the dark?	Yes	No

Is there a special toy or blanket your child likes to sleep with? If yes, where is this located?

Are there any special positioning needs at bed time? If yes, please describe.

Do you observe any special routine nightly? If yes, please describe.

Additional Information

Medication Management

This information should be updated whenever medication or dosages change. Please make sure that the school nurse always has an updated list of current medication.

Date: ______________________

Allergies: ______________________

Medication ______ Dosage ______ Time Given ______ Prescribing Physician ______	**Medication** ______ Dosage ______ Time Given ______ Prescribing Physician ______
Medication ______ Dosage ______ Time Given ______ Prescribing Physician ______	**Medication** ______ Dosage ______ Time Given ______ Prescribing Physician ______
Medication ______ Dosage ______ Time Given ______ Prescribing Physician ______	**Medication** ______ Dosage ______ Time Given ______ Prescribing Physician ______
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Medication ______ Dosage ______ Time Given ______ Prescribing Physician ______	**Medication** ______ Dosage ______ Time Given ______ Prescribing Physician ______

Seizures

Does your child have seizures? Yes No

If yes,

How often do the seizures occur? _____

How long do the seizures generally last? _____

Should the seizure be recorded? _____

What procedure do you follow and want to have followed in the event of a seizure? (For example, do you want the paramedics called?)

_____

_____

_____

_____

_____

_____

What usually happens after a seizure? (Will your child become sleepy, cranky, etc.)

_____

_____

_____

_____

_____

_____

Additional Information:

_____

_____

_____

_____

First Aid for Generalized Tonic Clonic (Grand Mal) Seizures

Keep calm and reassure other people who may be nearby.

Don't hold the person down or try to stop his movements.

Time the seizure with your watch.

Loosen ties or anything around the neck that may make breathing difficult.

Put something flat and soft, like a folded jacket, under the head.

Turn him or her gently onto one side. This will help keep the airway clear.

Do not try to force the mouth open with any hard implement or with fingers. **A person having a seizure CANNOT swallow his tongue.**

Don't attempt artificial respiration except in the unlikely event that a person does not start breathing again after the seizure has stopped.

Stay with the person until the seizure ends naturally, and be friendly and reassuring as consciousness returns.

*If any of the following conditions are present, medical attention is necessary immediately: diabetes, brain infections, heat exhaustion, pregnancy, poisoning, hypoglycemia, high fever, head injury.

**This information was provided by the Epilepsy Foundation. Further information can be found at http://www.epilepsyfoundation.org.*

Medical Release Form

Parent/Legal Guardian's Name:

Address: _____

Phone #s: Home_ ( ) -
Work ( ) -
Cell ( ) -
Other ( ) -

Children's Names	List all known medical conditions, including food allergies and/or drug allergies. In addition, include any and all over the counter and/or prescription drugs taken regularly.

In an emergency, please contact: _____

Relationship to child/children: _____

Phone #s: ( ) - ( ) -

OR

Contact: _____

Relationship to child/children: _____

Phone #s: ( ) - ( ) -

Physician's name: _____

Phone: _____

Address: _____

Dentist's name: _____

Phone: _____

Address: _____

Primary Insurance Company: _____

Phone: _____

Billing address: _____

Policy holder's name: _____

Address: _____

Relationship to children: _____

ID #: _____ Group/policy #: _____

Secondary Insurance Company: _____

Phone: _____

Billing address: _____

Policy holder's name: _____

Address: _____

Relationship to children: _____

ID #: _____ Group/policy #: _____

Statement of Consent: *(To be signed in the presence of a legalized notary public.)*

In the event of an emergency or non-emergency situation requiring medical treatment, I, _____ *, hereby grant permission for any and all medical and/or dental attention to be administered to my child/children, in the event of an accidental injury or illness, until such time as I can be con-tacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.*

Signature _____ Date: _____

Notarization:
On this _____ day of _____, _____, _____

Personally appeared before me in _____ County (in the state of _____)
and, in my presence, signed this medical release form.

Name of Notary Official: _____

Signature: _____ Commission Expires: _____