Record Keeping & Personal Care Guide

A Comprehensive Collection of Forms Including:

Medical Information · Personal Contact Numbers · Emergency Information
Insurance Information · Care Giver's Information · Organizational Tools

Ohio Developmental Disabilities Council

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Ohio Developmental Disabilities Council

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KEEPING VITAL RECORDS IS ESSENTIAL

Nothing is more important to your personal welfare than developing and maintaining a complete, up-to-date record-keeping system.

Record-keeping is essential. It's important for emergency hospital visits, insurance claims, respite care providers, or for documenting events and/or contacts about your medical needs. There is no other way to be prepared for events where current information is needed. Like it or not, understand it or not, there are forms you have to fill out everywhere you go! Having basic information on hand makes it manageable. It's also a way of noting family history, developmental landmarks, and the next logical steps which may help identify delays or detect problems.

PERSONAL, MEDICAL & INSURANCE INFORMATION

Below is a list of some of the important information that must be kept. It is not a complete list – that depends entirely on your disability or chronic illness. You may also decide to provide this information to other members of your family. This includes such personally identifiable information as:

Personal

- Birth certificates;
- Parent or guardian information;
- Location of wills and/or trusts;
- Daily care schedule;
- Grocery list;
- Budget information;
- Emergency contacts;

Medical

- Initial diagnosis;
- Health history;
- Physicians and other medical specialists;
- Medication and seizure logs;
- Daily care schedule;
- Immunization records;
- Office visits;
- Hospitalization information;
- Emergency contacts;

Insurance

- Health and life insurance information;

MEDICAL BILLS & INSURANCE CLAIMS

Keep all information needed to fill out forms. Keep a supply of blank claim forms, envelopes and stamps. Maintain files on all insurance company correspondence or claims. For tax purposes, keep an accurate account of what your policy covered and your out-of-pocket expenses.

EVALUATIONS, REPORTS & RECORDS

Keep copies or records of all correspondence (written and verbal) with service providers, medical support specialists and other professionals your child comes in contact with, along with all reports, records and other documents. They may contain important information in those cases where discrepancies may arise concerning your needs and/or program. Be certain copies of all medical reports are sent to your physician.

GETTING ORGANIZED

How your record-keeping system is organized is up to you. Just be certain it allows quick, easy access to all the information needed under any set of circumstance. Here are some recommendations. Purchase a three-ring binder with pockets for organizing and holding reports, etc. Insert blank pages and/or forms for recording your own information. Keep all current information in the notebook. Keep older information in a permanent, but portable, filing system. Purchase a small, portable file and file folders. File information using separate file folders for each category. To prevent record keeping from becoming a chore that keeps you from spending time with the important people in your life, organize early and in a manner that best suits your individual needs.

Personal Medical Information

Today's Date _____

Personal Information

Name _____ Age _____ Date of Birth _____

Birthplace _____ Sex (M) (F) Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Father/Legal Guardian _____ Social Security Number _____

Address *(if different)* _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Mother/Legal Guardian _____ Social Security Number _____

Address *(if different)* _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Emergency Contact _____ Relationship _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Health History

Initial Diagnosis _____

Diagnosis Date _____

Other Medical Conditions/Information _____

_____

_____

_____

_____

Allergies _____

_____

Medications _____

_____

_____

_____

_____

Assistive Devices _____

Eye and/or Hearing Devices _____

Family Physician _____

Office Address _____

City _____ State _____ Zip _____

Office Telephone (____) _____

Other Medical Specialist _____

Office Address _____

City _____ State _____ Zip _____

Office Telephone (____) _____

Other Medical Specialist _____

Office Address _____

City _____ State _____ Zip _____

Office Telephone (____) _____

Other Medical Specialist _____

Office Address _____

City _____ State _____ Zip _____

Office Telephone (____) _____

Tests & Evaluations

Conducted By _____

Office Telephone _____

Date Conducted _____

Test/Evaluation Result _____

_____

_____

_____

Conducted By _____

Office Telephone _____

Date Conducted _____

Test/Evaluation Result _____

_____

_____

_____

Conducted By _____

Office Telephone _____

Date Conducted _____

Test/Evaluation Result _____

_____

_____

_____

Conducted By _____

Office Telephone _____

Date Conducted _____

Test/Evaluation Result _____

_____

_____

_____

Conducted By _____

Office Telephone _____

Date Conducted _____

Test/Evaluation Result _____

_____

_____

_____

Medical Office Visits

Date _____

Reason for Visit _____

Physician/Specialist _____

Clinic Name _____

Office Telephone _____

Test Performed _____

Results & Treatment _____

_____

_____

Follow-Up Instructions _____

Notes _____

_____

Date _____

Reason for Visit _____

Physician/Specialist _____

Clinic Name _____

Office Telephone _____

Test Performed _____

Results & Treatment _____

_____

_____

Follow-Up Instructions _____

Notes _____

_____

Date _____

Reason for Visit _____

Physician/Specialist _____

Clinic Name _____

Office Telephone _____

Test Performed _____

Results & Treatment _____

_____

_____

Follow-Up Instructions _____

Notes _____

Date Prescribed or Changed	Medication	Doseage & Times Per Day	Doctor's Special Instructions	Side Effects or Concerns	Date Discontinued	Reason Discontinued

Insurance Information

Today's Date _____

Personal Information

Name _____ Age _____ Date of Birth _____

Birthplace _____ Sex (M) (F) Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Father/Legal Guardian _____ Social Security Number _____

Address *(if different)* _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Mother/Legal Guardian _____ Social Security Number _____

Address *(if different)* _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Emergency Contact _____ Relationship _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Insurance Company Information

Primary Insurance Carrier _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Policy Number _____ Group Number _____

Agent's Name _____

Agent's Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____

Secondary Insurance Carrier _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Policy Number _____ Group Number _____

Agent's Name _____

Agent's Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____

Medicaid Number _____ State _____ Date of Eligibility _____

Policyholder

Name _____

Address _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Cell Phone (____) _____

Date of Birth _____ Social Security Number _____

Family Members

Name _____ Relationship to Policyholder _____

Date of Birth _____ Social Security Number _____

Name _____ Relationship to Policyholder _____

Date of Birth _____ Social Security Number _____

Name _____ Relationship to Policyholder _____

Date of Birth _____ Social Security Number _____

Other Important Information

Pre-existing conditions not covered, waivers or riders attached to the policy, cost-share information, etc.

Community Resources Information

Today's Date _____

Personal Information

Name _____ Age _____ Date of Birth _____

Birthplace _____ Sex (M) (F) Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Father/Legal Guardian _____ Social Security Number _____

Address *(if different)* _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Mother/Legal Guardian _____ Social Security Number _____

Address *(if different)* _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Emergency Contact _____ Relationship _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Community Services (Nonprofit)

Name of Agency/Organization _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Contact Person _____

Description of Services _____

_____

_____

Name of Agency/Organization _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Contact Person _____

Description of Services _____

_____

_____

County Services

Name of Agency/Organization _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Contact Person _____

Description of Services _____

_____

_____

Name of Agency/Organization _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Contact Person _____

Description of Services _____

_____

State Agency/Organization

Name of Agency/Organization _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Contact Person _____

Description of Services _____

_____

_____

Name of Agency/Organization _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Contact Person _____

Description of Services _____

_____

Other Agency/Organization

Name of Agency/Organization _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Contact Person _____

Description of Services _____

_____

_____

Name of Agency/Organization _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Contact Person _____

Description of Services _____

_____

Today's Date _____

PERSONAL INFORMATION

Child's Name _____ Age _____ Date of Birth _____

Birthplace _____ Sex (M) (F) Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Father/Legal Guardian _____ Social Security Number _____

Address *(if different)* _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Mother/Legal Guardian _____ Social Security Number _____

Address *(if different)* _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Emergency Contact _____ Relationship _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

EMERGENCY CONTACTS/NUMBERS

Police, Fire & Ambulance – 911

Poison Control Center Telephone (____) _____

Family Physician _____ Telephone (____) _____

Pharmacy _____ Telephone (____) _____

Insurance Agency _____

Contact Person _____ Telephone (____) _____

Preferred Hospital _____ Telephone (____) _____

Neighbor _____ Telephone (____) _____

Neighbor _____ Telephone (____) _____

Relative or Close Friend _____

Relationship _____ Telephone (____) _____

Relative or Close Friend _____

Relationship _____ Telephone (____) _____

Household Routine

First aid kit location _____

Who, if anyone is allowed to visit the child when the parent isn't home? _____

_____

Is the child allowed to play outside? (Yes) (No)

If so, explain the boundaries, rules and length of time _____

_____

_____

Household rules providers and caregivers should follow when the parents are not home _____

_____

_____

_____

Child's Daily Schedule

7:00 AM _____

_____

8:00 AM _____

_____

9:00 AM _____

_____

10:00 AM _____

_____

11:00 AM _____

_____

12:00 PM _____

_____

1:00 PM _____

_____

2:00 PM _____

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3:00 PM _____

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4:00 PM _____

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5:00 PM _____

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6:00 PM _____

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7:00 PM _____

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9:00 PM _____

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10:00 PM _____

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11:00 PM _____

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12:00 AM _____

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1:00 AM _____

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2:00 AM _____

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3:00 AM _____

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4:00 AM _____

_____

5:00 AM _____

_____

6:00 AM _____

_____

Child's Medical Information

Child Diagnosed With _____

_____

Other Medical Conditions/Information _____

_____

_____

_____

_____

Family Physician _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____

Allergies _____

_____

Child's Medications

Medication	*Doseage*	*Time(s) Given*	*Prescribing Doctor*	*Emergency Telephone*

Seizures

Does the child have seizures? (Yes) (No)

If so, describe in detail _____

_____

_____

_____

General length of seizures _____

What procedure(s) should be followed during a seizure? (Do you want the paramedics to be called?) _____

_____

_____

_____

Should seizures be recorded? (Yes) (No)

What usually occurs following a seizure? (Will the child become sleepy, cranky, etc.) _____

_____

_____

Child's Behavior

Describe the child's normal behavior _____

_____

_____

Are there behaviors that are particularly challenging? _____

_____

_____

If so, what actions should be taken? _____

_____

_____

Is there a specific behavior plan for the child? If so, please describe _____

_____

_____

Has the child been known to wander or run away? _____

_____

_____

Activities that make the child happy, including toys, favorite games, etc. _____

_____

_____

Notes _____

Is the child verbal? (Yes) (No)

In case the child isn't verbal, how does he or she communicate? _____

_____

Specifically, how does the child communicate the need to eat? _____

_____

Ask to be picked up or held? _____

_____

Express interest in playing with a specific toy or game? _____

_____

Does the child use sign language as a form of communication? (Yes) (No)

If so, please explain how _____

_____

How does the child communicate the following?

Hungry _____

Thirsty _____

Tired _____

Happy _____

Hot _____

Cold _____

Brother _____

Sister _____

Mother _____

Father _____

Blanket _____

Bath _____

Toilet _____

Diaper _____

Bed _____

Dog _____

Cat _____

Video _____

TV _____

Music _____

Hello _____

Goodbye _____

Car _____

Walk _____

Outside _____

Inside _____

Sad _____

Angry _____

Play with me _____

Leave me alone _____

I want more _____

I am finished _____

Please _____

Thank you _____

I'm sick _____

Other _____

Cont...

Does the child use a specialized communication device? (Yes) (No)

If so, explain how the device is used _____

_____

_____

_____

_____

Where is it located and/or placed when not in use? _____

Child's Diet

Are there foods the child likes? _____

_____

Are there foods the child dislikes? _____

_____

Does the child have any food allergies? If so, please list and identify symptoms _____

_____

Does the child swallow well? (Yes) (No) Please explain _____

_____

Does the child need assistance while eating? (Yes) (No) If yes, what type of assistance is necessary? _____

_____

Is there a particular position or adaptive equipment necessary to assist the child during the meal? _____

_____

Please detail the location of the child's food, eating utensils and/or adaptive equipment _____

Child's Bed & Nap Times

At what time does the child go to bed? _____

What are the child's nap time(s)? _____

Does the child sleep alone? (Yes) (No)

Is the child afraid of the dark? (Yes) (No)

Is there a special toy or blanket the child likes to sleep with? _____

Are there special positioning needs at bed time? _____

_____

Is any special nightly routine observed? _____

_____

Does the child usually sleep through the night? (Yes) (No) If not, explain the activities required to either induce sleep or keep the child occupied while awake. _____

_____

Personal Hygiene

Does the child use the toilet? (Yes) (No)

Can he or she use the toilet alone? (Yes) (No)

If not, describe the special assistance required _____

_____

Does the child require diapers? (Yes) (No)

Training Pants (Yes) (No)

Use a potty chair? (Yes) (No)

Can the child brush his or her own teeth? (Yes) (No)

If yes, explain how _____

_____

Can the child dress himself or herself? (Yes) (No)

If yes, what assistance is necessary? _____

_____

Can the child bathe himself or herself? (Yes) (No)

Is adaptive equipment required? (Yes) (No)

If yes, explain how the equipment is used _____

_____

Adaptive/Assistive Equipment

Does the child use adaptive equipment? (Yes) (No)

Describe the equipment and how it should be used _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

In Case Of Emergency

Today's Date _____

Personal Information

Child's Name _____ Age _____ Date of Birth _____

Birthplace _____ Sex (M) (F) Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Height _____ Weight _____

Hair Color _____ Eye Color _____

Distinguishing Marks _____

_____

Emergency Contact Numbers

Father/Legal Guardian _____ Social Security Number _____

Address *(if different)* _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Mother/Legal Guardian _____ Social Security Number _____

Address *(if different)* _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Primary Emergency Contact _____ Relationship _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Secondary Emergency Contact _____ Relationship _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Primary Physician _____

Office Telephone (____) _____ Emergency Telephone (____) _____

Notes _____

Secondary Physician _____

Office Telephone (____) _____ Emergency Telephone (____) _____

Notes _____

What I want an emergency physician to know _____

Prescription Drugs

Medication	Doseage	Frequency	Reason

Allergies

Type	Severity	Frequency/Last Occurrence

Chronic Conditions

Type	Severity	Notes

Insurance Information

Primary Insurance Carrier _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Policy Number _____ Group Number _____

Agent's Name _____

Agent's Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____

Secondary Insurance Carrier _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Policy Number _____ Group Number _____

Agent's Name _____

Agent's Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____

Medicaid Number _____ State _____ Date of Eligibility _____

Notes

Grocery List

Make grocery shopping easier by always going with a prepared list. The following template can be copied and used again and again.

Produce
__ Potatoes
__ Mushrooms
__ Onions
__ Lettuce
__ Tomato
__ Carrots
__ Broccoli
__ Cauliflower
__ Spinach
__ Bananas
__ Apples
__ Oranges
__ Grapes
__ Melon
__ Berries
__ Lemon/Lime
__ _____
__ _____

Deli
__ Deli Meats
__ Deli Salads
__ Deli Cheese
__ _____
__ _____

Snacks
__ Cookies
__ Crackers
__ Graham Crackers
__ Chips
__ Popcorn
__ _____
__ _____

Breads
__ Bread
__ Hot Dog Buns
__ Hamburger Buns
__ Bagels
__ English Muffins
__ Croutons
__ _____
__ _____

Beverages
__ Juice
__ Kool Aid
__ Lemonade
__ Pop/Soda
__ Bottled Water
__ Chocolate Syrup
__ Coffee
__ Tea
__ _____
__ _____

Condiments
__ BBQ Sauce
__ Mustard
__ Mayonnaise
__ Pickles/Relish
__ Ketchup
__ Marinade
__ Salad Dressings
__ Jelly/Jam
__ Peanut Butter
__ Seasoning Packet
__ _____
__ _____

Canned Goods
__ Tuna
__ Spaghetti Sauce
__ Pizza Sauce
__ Tomato Products
__ Mushrooms
__ Soup
__ Beans
__ Corn
__ _____
__ _____

Canned Fruits
__ Applesauce
__ Fruit Cups
__ Pineapple
__ Peaches
__ Pears
__ Fruit Cocktail
__ Raisins
__ _____
__ _____

Bakery
__ Donuts
__ Cake
__ Pie
__ Cinnamon Rolls
__ Brownies
__ Cookies
__ _____
__ _____

Dairy
__ Milk
__ Orange Juice
__ Dinner Roll Dough
__ Cookie Dough
__ Butter/Margarine
__ Eggs
__ Yogurt
__ Sliced/Shredded Cheese
__ Cream Cheese
__ Sour Cream
__ Cottage Cheese
__ _____
__ _____

Cereals
__ Cereal
__ Granola Bars
__ Oatmeal
__ Hot Cereal
__ _____
__ _____

Pasta
__ Spaghetti
__ Mac & Cheese
__ Lasagna Noodles
__ Rice
__ Noodle & Sauce Mix
__ _____
__ _____

Ethnic Foods
__ Taco Mix
__ Tortilla Shells
__ Taco Sauce
__ Soy Sauce
__ Teriyaki Sauce
__ _____
__ _____

Meat
__ Ground Beef
__ Chicken
__ Ground Turkey
__ Beef Roast
__ Steaks
__ Burger Patties
__ Pork Chops
__ Pork Roast
__ Bacon
__ Hot Dogs
__ Sausage
__ Brats
__ Ham
__ _____
__ _____

Baking
__ Sugar
__ Flour
__ Pancake Mix
__ Muffin Mix
__ Cake/Brownie Mix
__ Pie Crust
__ Marshmallows
__ Jello
__ Pudding
__ Pancake Syrup
__ Honey
__ Chocolate Chips
__ _____
__ _____

Health/Beauty
__ Suntan lotion
__ Shampoo
__ Conditioner
__ Deodorant
__ Bath Soap
__ Feminine Supplies
__ Make-Up
__ Toothpaste
__ Mouthwash
__ Lotion
__ Band Aids
__ Antiseptic Cream
__ Medicines
__ Vitamins
__ _____
__ _____

Frozen Foods
__ Frozen Meats
__ Frozen Veggies
__ Frozen Fruits
__ Waffles
__ French Fries
__ Pizza
__ Ice Cream
__ _____
__ _____

Paper Goods
__ Napkins
__ Paper Towels
__ Toilet Paper
__ Tissues
__ Paper Plates
__ Paper Cups
__ Plastic Bags
__ Aluminum Foil
__ Plastic Wrap
__ Wax Paper
__ _____
__ _____

Cleaners
__ Laundry Detergent
__ Fabric Softener
__ Dishwasher Soap
__ Bleach
__ Disinfectant
__ Dusting Spray
__ _____
__ _____

Baby Items
__ Baby Food
__ Diapers
__ Baby Wipes
__ _____
__ _____

Other
__ Pet Food
__ Light Bulbs
__ Cards/Gift Wrap
__ _____
__ _____

Phone List

Important Phone Numbers

My Home Telephone _____

My Cell Phone _____

Mother/Guardian _____

Father/Guardian _____

Primary Physician _____

Secondary Physician _____

Dentist _____

Optometrist _____

Neighbor _____

Neighbor _____

Babysitter _____

Personal Budget Worksheet

Income

Income	*Monthly Amount*
Net Pay	
Second Job - Net Pay	
Investments	
Interest	
Other	
TOTAL INCOME	***$.***

Routine (Fixed) Expenses

Expense	*Monthly Amount*
Cable TV	
Car Payments	
Child Care	
Credit Card Payments	
Insurance (Health, Life, Property)	
Internet Service Provider	
Rent or Mortgage	
Student Loans	
Taxes	
Telephone	
Utilities	
Other	
TOTAL ROUTINE EXPENSES	***$.***

Variable Expenses

Expense	*Monthly Amount*
Babysitting	
Food	
Transportation (Gas, Maintenance, Parking, Taxis)	
Vacation	
Clothing (Purchases, Dry Cleaning)	
Education	
Entertainment	
Gifts (Birthdays, Holidays, Weddings)	
Hair Care, Body Care (Hair Cuts, Manicures, Tanning)	
Medication, Medical Visits, Glasses/Contacts	
Savings	
Other	
TOTAL VARIABLE EXPENSES	***$.***

Total monthly fixed and variable expenses	$.
Difference between monthly income and expenses = surplus / (deficit)	$.

Ohio
Developmental
Disabilities Council

It is the mission of the Ohio Developmental Disabilities Council to create change that improves independence, productivity, and inclusion for people with developmental disabilities and their families in community life.

www.ddc.ohio.gov