

KIDBASE

Kids' Information Database Access System for Emergencies



Photograph of Child
(optional)

Helping emergency personnel care for your child with special health care needs

For questions about KIDBASE, please email Kid.Base@ncmail.net or call (919) 855-3935.

Keep copies of this form with: (1) Your Child in backpack/on wheelchair; (2) School Nurse or Teacher; (3) Daycare; (4) Any other person your child is with frequently.

Please keep this form updated as your child's medical information and/or care changes. An electronic copy of this form, which allows you to easily update and save your child's medical information, can be found at www.ncems.org/kidbase.htm. Once the form has been completed, send the KIDBASE postcard to your KIDBASE coordinating agency or contact them directly to let them know your child is enrolled.

PARENT/GUARDIAN

Instructions: Parent/Guardian fills out this section.

(Consider contacting your child's physician if you need help filling out this section.)

CHILD'S NAME: _____ NICKNAME: _____
LAST NAME FIRST NAME

DATE OF BIRTH: / / MALE FEMALE CURRENT WEIGHT: _____ kgs HEIGHT: _____
mm dd yyyy

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____
STREET NAME or P.O. BOX APT. #

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____
(IF DIFFERENT THAN HOME ADDRESS) STREET NAME or P.O. BOX APT. #

NAME OF PARENT(S)/PRIMARY CAREGIVER(S): _____

PREFERRED CONTACT PHONE NUMBER: EMAIL ADDRESS: _____
(IF APPLICABLE)

Emergency Contact Information (Other than Parent/Primary Caregiver)

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO CHILD: _____ PREFERRED CONTACT PHONE NUMBER:

PRIMARY CARE PHYSICIAN: _____

OFFICE PHONE: EMERGENCY PHONE:

PREFERRED SPECIALTY PHYSICIAN: _____ SPECIALTY: _____

OFFICE PHONE: EMERGENCY PHONE:

PRIMARY LANGUAGE: _____ COMMUNICATION/LEVEL OF FUNCTION: VERBAL NONVERBAL

HEARING IMPAIRED: YES NO LEGALLY BLIND: YES NO ABLE TO WALK: YES NO ABLE TO SPEAK: YES NO

ANY COGNITIVE/MENTAL DIFFICULTIES: YES NO ANY SENSORY ISSUES: YES NO

CAN HE OR SHE BE UNDERSTOOD BY OTHERS?: YES NO CAN HE OR SHE UNDERSTAND OTHERS?: YES NO

DOES ANYTHING IN PARTICULAR UPSET OR OVERSTIMULATE YOUR CHILD?: _____
EXAMPLE: bright lights, loud noises, medical equipment, touch, etc.

PHYSICIAN

Instructions: Child's Physician fills out this section.

Please print or type.

CHILD'S DIAGNOSES: _____ CHILD'S PAST PROCEDURES: _____

cont. on back

Baseline Vital Signs

DNR STATUS: _____

SKIN COLOR: _____

PULSE RATE: _____
SITE BEST TAKEN

BLOOD PRESSURE: _____
SITE BEST TAKEN

RESPIRATORY RATE: _____
BREATH SOUNDS

PULSE O₂ ROOM AIR: Pulse O₂ on _____ liter/min Oxygen

BROSELOW RESUSCITATION TAPE COLOR: _____ WEIGHT (Kgs) _____

BLOOD SUGAR LEVEL: _____

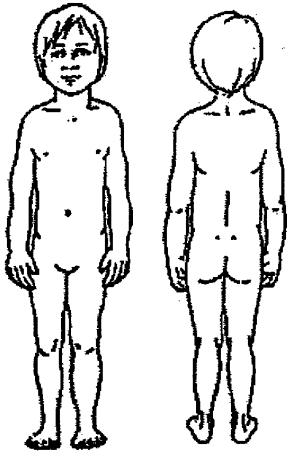
TEMPERATURE: _____
HOW TAKEN

PUPILS: _____

OTHER SIGNIFICANT BASELINE FINDINGS (lab, x-ray, ECG, EKG, etc.): _____

Instructions:

Shade areas of paralysis or diminished sensation.
 Denote the location of Venous Access Devices.



Special Technologies/Devices

- NEBULIZER TRACHEOSTOMY VENTILATOR
- CENTRAL VENOUS CATHETER, IMPLANTED PORT, OR OTHER VENOUS ACCESS DEVICE (denote on diagram)
- PACEMAKER VENTRICULAR PERITONEAL SHUNT DIALYSIS SHUNT OSTOMY STOMA
- GASTROSTOMY TUBE OR BUTTON Size: _____
- VAGAL NERVE STIMULATOR OTHER (Describe): _____

Special Equipment Used to Care for this Child

- CONTINUOUS OXYGEN Rate and Route: _____ VENTILATOR, Vent Settings: _____
- BAG VALVE, Size: _____ WITH MASK, Mask Size: _____
- TRACH TUBE, Size: _____ IV ACCESS LOCATION, Needle Type & Size: _____
- SUCTION CATHETER, Size: _____
- OTHER SPECIAL CONSIDERATIONS (i.e, Past Successful Interventions): _____

Any special transportation requirement such as position of comfort or wheelchair?

Allergies (List all and indicate child's reaction to each.)

- MEDICATIONS: _____
- _____
- MEDICATIONS TO AVOID: _____
- FOODS: _____ LATEX: _____

Medications

DRUG NAME	DOSAGE	WHEN/HOW TAKEN	SIDE EFFECTS/SPECIAL INSTRUCTIONS

PHYSICIAN/PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME: _____

I have reviewed the information contained in this document and consent to the information being made available to emergency care personnel to prepare for and assist my child during an emergency. I understand that it is my responsibility to update this form when my child has significant changes in his medical condition and/or care. I also understand that this information will be kept confidential and only shared with emergency care providers that may be asked to care for my child during an emergency.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

PRINT NAME: _____