



Effective Date	

Emergency Planning Medical Form

Emergency Information

Child's Name:	Sex: Male Fe	male C	Other	
Birth Date:	Approximate W	eight:	lb	Kg
Address:				
Emergency Contact 1:	Relationship:		Phone #:	
Emergency Contact 2:	Relationship:		Phone #:	
Hospital Facility Preference:				
Subspecialty Care Provider:	Specialty:		Phone #:	
Primary Care Provider:	Phone #:			
Child-Specific Emergency Instructions/Pro	otocols: Yes/No	*If y	es, see paperv	vork*
Presence of DNR/Limitations: Yes/No	*If yes, s	see paperv	work*	
Allergies				
Allergies and Reactions:				
Diagnoses				
Describe Child's Medical Diagnoses:				
Medications				
Current Medications:				

Medical Equipment		
List Any Medical Equipment (Settings,	, Sizes, etc.):	
Things to Avoid		
Procedures, Words, Noises, Positions:		
Comforting or Calming Things		_
Objects, Words, Sounds, Songs, Medic	cations:	
Anything that may help in case of	an emergency	
	_	
This form must be completed and s	submitted by the parent/legal guardian o	of the child.
Permission to share your child's information agency/organization), and any hospital controls.	ation with (name of school district) and (na destination in case of an emergency.	me of EMS
Signature:	Date:	
	Relation:	
you also consent to the information being	ormation with the above school district and leads shared with additional EMS agencies and a For Life) if necessary during emergency situates	air ambulances
Additional Forr	ms Included (check all that apply)	
	DNR FormMedication List	Other
If you have questions about this form, co	ontact Dr. Michael K. Kim, Associate Professor	of Emergency

Medicine and Pediatrics, University of Wisconsin-Madison, (mkkim@medicine.wisc.edu)

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