MY EMERGENCY ACTION PLAN

PROBLEM & SIGNS	NEEDED ACTION	WHAT SHOULD BE SEEN
1.		
2.		
3.		
4.		
5.		

SIGNATURES

Physician/Provider Signature:_____

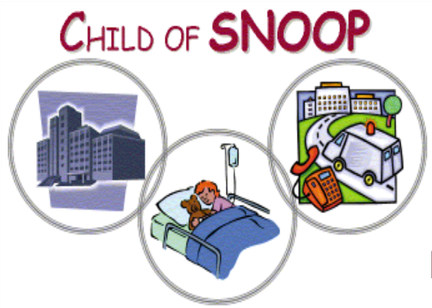
Print Name:_____

Parent/Guardian Signature:_____

Print Name:_____

COMPLETION & REVISION STATUS

Completion Date:_____ Revised & Initials:_____ Revised & Initials:_____



S-I-M-P-L-E

FORM

Special **I**nformation for **M**edical **P**roviders **L**egend in **E**mergency

Oklahoma EMSC Emergency Medical Services for Children RESOURCE CENTER

Name:_____ Nickname:_____ D-O-B:_____

LANGUAGE(S)

Primary:_____ Secondary:_____ Tertiary:_____

Responsible Caregiver:_____

ADDRESSES

Physical:_____

Mailing:_____

PHONES

Home:_____ Work:_____ Cellular:_____

OTHER SUPPORTERS TO CONTACT

1. Name:_____ Relationship:_____ Phone:_____
2. Name:_____ Relationship:_____ Phone:_____
3. Name:_____ Relationship:_____ Phone:_____

PHYSICIANS

Primary Physician:_____

Office:_____ Fax:_____ Other:_____

Specialty Physician:_____ Specialty:_____

Office:_____ Fax:_____ Other:_____

Specialty Physician:_____ Specialty:_____

Office:_____ Fax:_____ Other:_____

PHARMACY(S)

Regular Pharmacy:_____ Contact:_____ Phone:_____

24-hour Pharmacy:_____ Contact:_____ Phone:_____

MEDICAL CARE FACILITIES

Primary ED:_____ Contact:_____ Phone:_____

Tertiary Care ED:_____ Contact:_____ Phone:_____

Tertiary Care Center:_____ Contact:_____ Phone:_____

HOW I NORMALLY APPEAR

VITAL SIGNS

Heart Rate:_____ Breathing Rate:_____ Blood Pressure:_____

Temperature:_____ Oxygen Saturation:_____ Other:_____

HOW I LOOK and ACT

Describe your child's typical color, physical differences, activity level, movement capabilities, awareness to surroundings, and responsiveness to others under their normal conditions._____

TECHNOLOGY DEVICES I USE

Type:_____ Supplier:_____
Contact:_____ Phone:_____
Type:_____ Supplier:_____
Contact:_____ Phone:_____
Type:_____ Supplier:_____
Contact:_____ Phone:_____
Type:_____ Supplier:_____
Contact:_____ Phone:_____

THINGS THAT ARE BAD FOR ME

KNOWN ALLERGIES

THINGS TO AVOID

Describe everything that should be avoided by your child, such as foods, medications, procedures, etc and why..._____

MY IMMUNIZATION HISTORY

DPT:					Hep A:					
OPV:					Hep B:					
MMR:					Varicella:					
HIB:					TB-Status:					
Other:					Other:					

MY DIAGNOSES, MEDICATIONS I TAKE, AND WHY

1._____ Medications:_____
Synopsis:_____
2._____ Medications:_____
Synopsis:_____
3._____ Medications:_____
Synopsis:_____
4._____ Medications:_____
Synopsis:_____
5._____ Medications:_____
Synopsis:_____
6._____ Medications:_____
Synopsis:_____

MY NORMAL DIAGNOSTIC WORK

LAB / RADIOLOGY / ECG / EEG / EMG / ETC.

MY LOCAL EMS FRIENDS

Agency:_____ Contact:_____
Address:_____
Phone:_____ Fax:_____ E-mail:_____
Other Information:_____