Note: For OEMS use only

Date Received:

KIDBASE

Kids' Information Database Access System for Emergencies

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

Photograph of Child (optional)

Send this completed form to: KIDBASE Program c/o NC Office of EMS, 2707 Mail Service Center, Raleigh, NC 27699-2707

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.

You will be asked to update this form on a yearly basis.

If your child has more frequent changes in his medical condition and/or care, please email them to KID.BASE@ncmail.net.

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: _____ (LAST NAME) _____ (FIRST NAME) NICKNAME: _____

DATE OF BIRTH: ____/____/____ (mm/dd/yyyy) ☐ MALE ☐ FEMALE CURRENT WEIGHT: _____kgs HEIGHT: _____

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

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

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

PHYSICIAN cont.

Baseline Vital Signs

DNR STATUS:_____ SKIN COLOR:_____

PULSE RATE:_____ _____ BLOOD PRESSURE:_____ _____
SITE BEST TAKEN *SITE BEST TAKEN*

RESPIRATORY RATE:_____ _____ PULSE Ox ROOM AIR: Pulse Ox on _____ liter/min Oxygen
BREATH SOUNDS

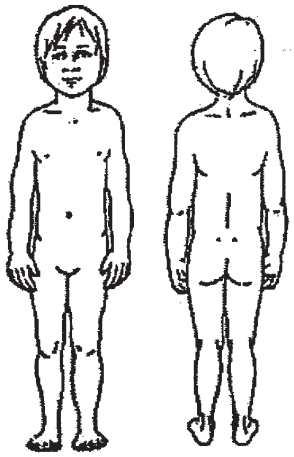
BROSELOW RESUSCITATION TAPE COLOR:_____WEIGHT (Kgs)_____ BLOOD SUGAR LEVEL:_____

TEMPERATURE:_____ _____ PUPILS:_____
HOW TAKEN

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 childs 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 siginificant 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:_____