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ACKNOWLEGEMENTS

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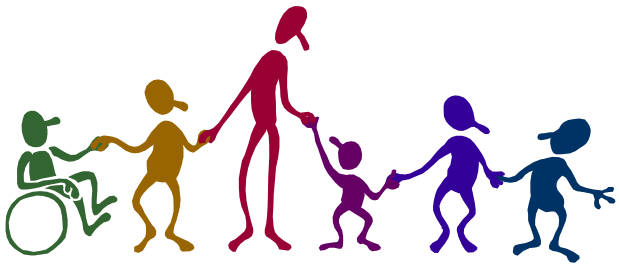
Fall 2010



This notebook can be downloaded for free at:

www.FamilySupportNetworkWNC.org

www.FIRSTwnc.org

www.youfindservices.org

INTRODUCTION TO THE CARE NOTEBOOK

What is this notebook for?

A way to simplify record keeping and store information about many services available to you and your child.

A place to collect and organize the important papers that accumulate as your child grows.

To keep track of information you receive for and about your child as he or she journeys through childhood and beyond.

How to get the most out of this notebook:

Take your notebook with you to all scheduled appointments.

Update the information in each section when you get new information.

Review your child's health care with any health care provider or anyone who is not familiar with your child.

Make this notebook work for you:

Create your own sections.

Remove and rearrange pages to fit your needs.

Personalize it with drawings, stickers, photographs, and special articles you find helpful.

ALL ABOUT MY CHILD

Quick Reference

- Child's Home Address
- Primary Care Doctor / Medical Home
- Urgent Care / After Hours / Advice Nurse
- Family Contact Information
- Allergies
- Insurance Information

Important Contact Information

My Child's Care Coordinators

Things You Need To Know About My Child to Support Him / Her

My Child

My Child's Birth Story

QUICK REFERENCE

Child's Home Address:

Primary Care Doctor/Medical Home Provider

Name: After hours Phone:

Phone Number: Fax:

Urgent Care - After Hours - Advice Nurse

Name:

Phone:

Family Contact Information

Name: Work Phone:

Home Phone: Cell Phone:

Name: Work Phone:

Home Phone: Cell Phone:

Emergency Contact: Relationship:

Home Phone: Work Phone:

Cell Phone:

Allergies

Food, Medication, etc.:

Insurance Information

Insurance: Policy #:

Phone: Subscriber #:

Fax #: Contact Person:

Insurance: Policy #:

Phone: Subscriber #:

Fax #: Contact Person:

IMPORTANT CONTACT INFORMATION

Life-Threatening Emergency: Call 911

Primary Care Doctor - Medical Home

Name:

Address:

City: Zip:

Care Coordinator:

Phone: Fax:

Hours: Email:

Urgent Care - After Hours - Advice Nurse

Name:

Address:

City: Zip:

Phone: Fax:

Hours: Email:

Primary Hospital

Hospital:

Information Phone Number:

Address:

Emergency Room Phone Number:

Special Transportation

Transportation Agency:

Contact Name: Phone:

Address:

Transportation Agency:

Contact Name: Phone:

Address:

Specialist Doctors - Therapists - Other Care Providers

Provider: Specialty:

Clinic: Phone:

Address: Fax:

Hours: Email:

Provider: Specialty:

Clinic: Phone:

Address: Fax:

Hours: Email:

Provider: Specialty:

Clinic: Phone:

Address: Fax:

Hours: Email:

Provider: Specialty:

Clinic: Phone:

Address: Fax:

Hours: Email:

Medical Equipment Supplier

Supplier: Product:

Contact: Phone:

Address: Fax:

Hours: Email:

Notes:

Community Agencies

Agency: Service:

Contact: Phone:

Address: Fax:

Hours: Email:

Agency: Service:

Contact: Phone:

Address: Fax:

Hours: Email:

Notes:

Home Nursing Agencies

Agency: Service:

Contact: Phone:

Address: Fax:

Hours: Email:

Notes:

Agency: Service:

Contact: Phone:

Address: Fax:

Hours: Email:

Notes:

Agency: Service:

Contact: Phone:

Address: Fax:

Hours: Email:

Notes:

Infant Program - Preschool - School

School: Teacher:

Address: Phone:

Notes: Email:

School: Teacher:

Address: Phone:

Notes: Email:

School Nurse

Name: Phone:

Address: Email:

Notes:

Child Care Provider

Name: Phone:

Address: Email:

Notes:

Name: Phone:

Address: Email:

Notes:

Respite Care Provider

Name: Phone:

Address: Email:

Notes:

Pharmacy Used for Prescriptions

Pharmacy: Product:

Pharmacist: Phone:

Address: Fax:

Hours: Email:

Notes:

Dentist - Orthodontist

Name: Phone:

Address: Fax:

Hours: Email:

Notes:

Social Worker

Name: Phone:

Address: Email:

Notes:

Public Health Department - Nurse

Name: Phone:

Address: Email:

Nutritionist

Name: Phone:

Address: Email:

Other

Name: Phone:

Title/Agency: Notes:

Name: Phone:

Title/Agency: Notes:

Name: Phone:

Title/Agency: Notes:

Name: Phone:

Title/Agency: Notes:

Name: Phone:

Title/Agency: Notes:

Name: Phone:

Title/Agency: Notes:

Name: Phone:

Title/Agency: Notes:

MY CHILD'S
CARE COORDINATORS

Agency:

Care Coordinator: Phone:

Address: Fax:

City: Zip:

Notes:

Agency:

Care Coordinator: Phone:

Address: Fax:

City: Zip:

Notes:

Agency:

Care Coordinator: Phone:

Address: Fax:

City: Zip:

Notes:

Agency:

Care Coordinator: Phone:

Address: Fax:

City: Zip:

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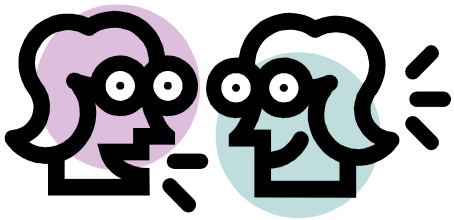


THINGS YOU NEED TO KNOW ABOUT MY CHILD TO SUPPORT HIM / HER

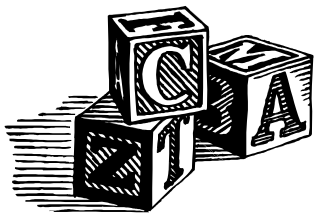
Name my child prefers: **Date:**

Some things my child likes are:

My child likes it when you:

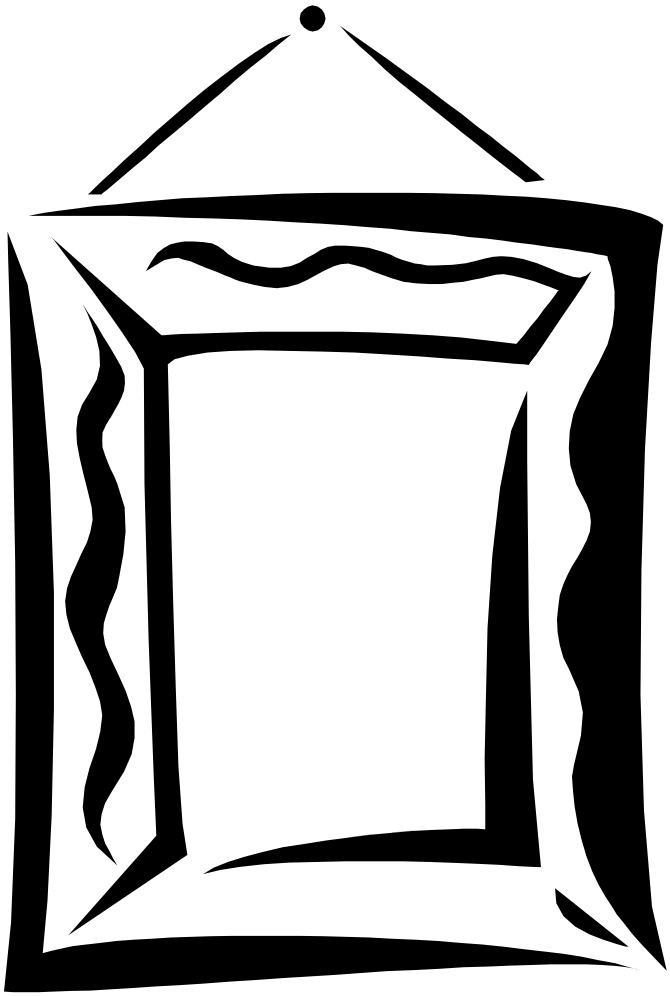
My child doesn't like it when you:

My child cooperates best / is motivated when you:



My child's strengths / personality at this age are:

MY CHILD



(Place a photo of your child here)

MY CHILD'S BIRTH STORY

Date of birth:

MEDICAL INFORMATION

Medical Home Overview

Medical and Developmental History

Height and Weight

My Child's Teeth

Medication Log

Allergic Reaction Tracking Form

My Child's Allergies

Immunization Chart

Tests / X-Rays / Labs

Emergency Department (Room) Visits / Hospitalizations

My Child's Emergency Medical Care

Equipment Log

Notes to Take To the Doctor

*** Update this information at each visit; it will be a continuous record of your child's medical care.*

MEDICAL HOME OVERVIEW

Establish a Medical Home for your child: a place where you take your child for <u>all</u> health care needs. According to other parents, the following ideas describe a good Medical Home:

A. Quick response to calls concerning my child.
B. Know my child's past history.
C. Update-to-date knowledge regarding my child's medical concerns.
D. Community resources available.
E. Respect for parents' concerns.
F. Respect for parents' knowledge of their child's needs.
G. Sees each child behind the disability and willing to provide medical care.
H. Patient with child's behavior.
I. Family centered approach to working with my child.
J. Provides good coordination with all specialists and follows up on results from specialists.
K. Not "territorial" with treatment options.
L. Willing to discuss concerns regarding proposed treatment and/or alternative treatments suggested by parents.
M. Advocate and suggest services the family may benefit from.
N. A good listener and open communication lines with parents / specialists/ care givers.
O. Cooperation of staff to assist in getting information to doctor or providing information (records) to child's specialist, case manager, etc.
P. Respect family's religion and ethical beliefs.
Q. Respect for parents' time.

For More Information About a Medical Home:		
Family Support Network	www.FamilySupportNetworkWNC.org	(828) 213 - 0033
Exceptional Children's Assistance Center	www.ecac-ParentCenter.org	1-800-962-6817
Center for Medical Home Improvement	http://www.MedicalHomeImprovement.org/knowledge/families.html	
National Center for Medical Home Implementation	http://www.MedicalHomeInfo.org/	

MEDICAL & DEVELOPMENTAL HISTORY

Child's Name: **Birth Date:**

Pregnancy History

Mother's age at start of pregnancy:

Length of Pregnancy: Maternal Weight Gain:

Prescribed or over the counter medications taken during pregnancy (include vitamins):

Month first felt baby move: _____ Months

During pregnancy, baby was: _____Quiet ____ Active ____ Very Active

As the pregnancy progressed, were there any changes in your baby's activity level? If yes, please describe:

Concerns, complications, or illnesses during pregnancy:

Previous number of pregnancies: Number of living children:

Describe any difficulties during previous pregnancies:

Labor and Delivery

Labor for my child was: ____ Uncomplicated ____ Complicated / Difficult

Describe any difficulties:

Was internal fetal monitoring used during labor?

Did membranes rupture? If yes, number of hours prior to delivery:

Were you awake during delivery?

Labor was ____ Spontaneous ____ Induced

Was anesthesia used? If yes, what type?

Type of birth:

- ____ Vaginal: ____ Head First ____ Breech ____ Forceps used
- ____ Cesarean Section. Reason for C-section:

Baby was born: ____ Full-term ____ Late ____ Premature (If premature, # of weeks: _____)

Birth / Early Infancy

Birth weight: Length:

Head Circumference: APGAR score at 1 minute:

Did baby cry immediately?	APGAR score at 5 minutes:
Did baby need help with breathing?	If yes, how long?
Baby was in hospital _____ days _____ weeks	
Was baby in NICU (neonatal intensive care unit)?	If yes, how long?
Was medication prescribed for the baby?	If yes, describe reason.
While in hospital, did baby require special care after birth (such as therapy, evaluation by a specialist)?	If yes, describe reason.

Describe any difficulties with the baby immediately after birth:

Did the baby have difficulties during the first months:	____ Feeding	____ Sleeping
	____ Alertness	____ Movement
	____ Jaundice	____ Other:

Has your child had any of the following illnesses? If yes, list at what age.

_____Chicken Pox	_____German Measles	_____Hepatitis	_____Mumps
_____Whooping Cough	_____Meningitis	_____Measles	_____CMV

Other:

Has your child had difficulty with any of the following? If yes, list at what age.

_____Skin rashes	_____Anemia	_____Diarrhea	_____Speech
_____Breach holding spell	_____Coordination	_____ Swallowing	_____ Turns Blue
_____ Frequent Falling	_____ Sucking	_____ Staring Spells	_____ Vomiting
_____ Respiratory Problems	_____ Asthma	_____ Fainting Spells	_____ Dental
_____ Ear Infections	_____ Heart	_____ Allergies	_____ Feeding
_____ Constipation	_____ Special dietary considerations		
_____ Other:			

Has your child seen a **vision** specialist?
If yes, give doctor's name and reason for visit.

Has your child seen an **ear** specialist?
If yes, give doctor's name and reason for visit.

Has your child had a **hearing test**?
If yes, give reason for visit.

Family Medical History

For the following, please check any conditions present in the child's biological family.
If checked, please explain in space provided below.

	Mother	**Mother's Family**	**Father**	**Father's Family**
Birth Defects:				
Inherited Disorder:				
Infant Deaths:				
Learning Problems:				
Intellectual Disabilities:				
Muscle Disease/Weakness:				
Neurological Disease:				
Substance Abuse:				
Mental Illness:				
Vision Disorder:				

	Mother	Mother's Family	Father	Father's Family
Hearing Disorder:				
Epilepsy/Seizures:				
Diabetes:				
Behavior Disorders:				
Emotional Disorders:				
Other health problems:				

Explanation:

Does any OTHER family member have difficulties similar to your child's?
If yes, please explain.

Child's Developmental Milestones

List the age that your child first did the following.

	Age:		Age:
Held head steady when being carried	_____	Drank from a cup	_____
Rolled from back to tummy	_____	Responded to name	_____
Sat up	_____	Said first word	_____
Crawled on hands and knees	_____	Fed self with fingers	_____
Pulled to standing	_____	Used a spoon	_____
Walked holding on to things	_____	Spoke with 3 or more word phrases	_____
Walked alone	_____	Toilet trained	_____
Age you first suspected your child had a problem	_____		

Social History

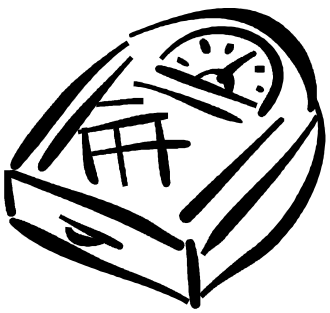
List any siblings or other people living in household.

Name:	Relation:	Birth Date:

Other Information

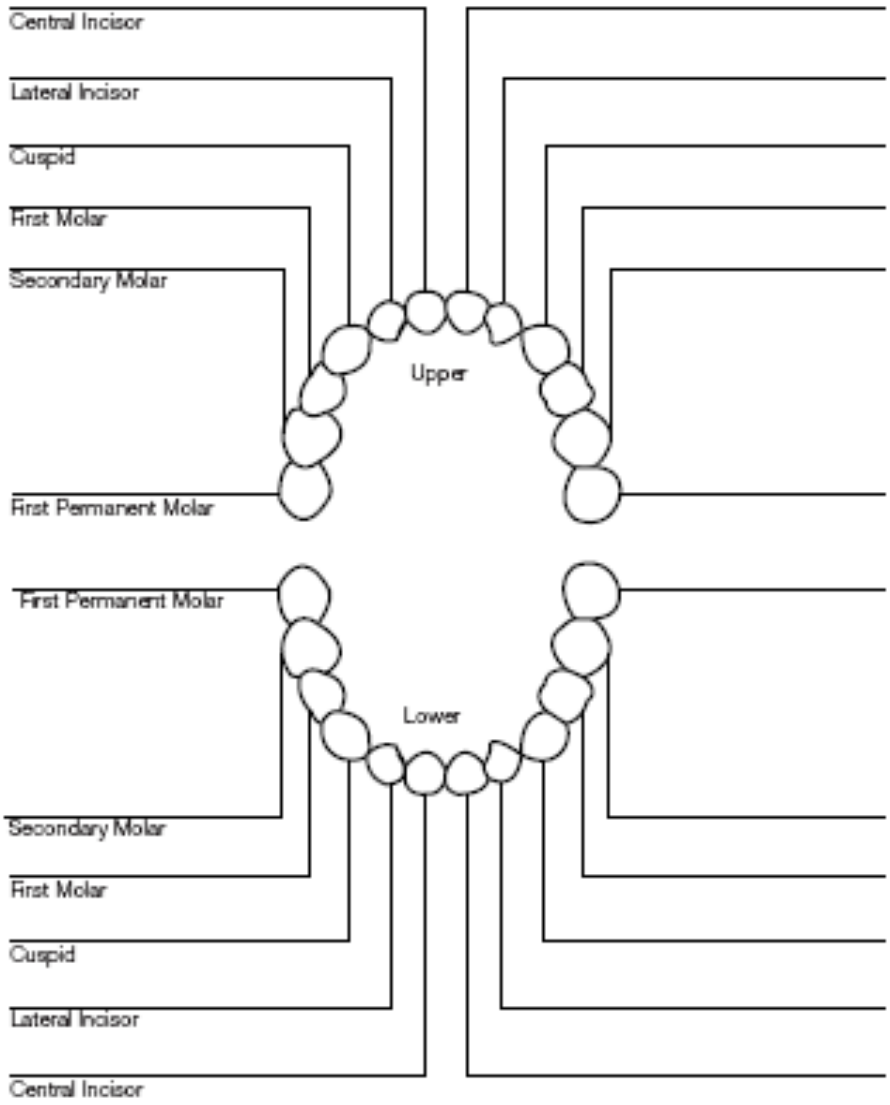
HEIGHT & WEIGHT LOG

Date:	Height:	Weight:	Percentile:	Head Circumference:	Comments related to child's growth:



MY CHILD'S BABY TEETH

Record when your child's teeth emerge and are lost in the diagram below.



The following chart shows when primary teeth (also called baby teeth or deciduous teeth) erupt and shed. It's important to note that eruption times can vary from child to child.

UPPER TEETH	WHEN BABY TOOTH EMERGES	WHEN BABY TOOTH FALLS OUT
Central Incisor	8 – 12 Months	6 – 7 Years
Lateral Incisor	9 – 13 Months	7 – 8 Years
Canine (Cuspid)	16 – 22 Months	10 – 12 Years
First Molar	13 – 19 Months	9 – 11 Years
Second Molar	25 – 33 Months	10 – 12 Years

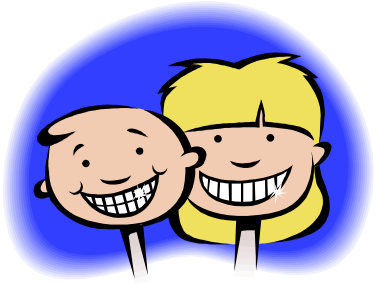
LOWER TEETH	WHEN BABY TOOTH EMERGES	WHEN BABY TOOTH FALLS OUT
Second Molar	23 – 31 Months	10 – 12 Years
First Molar	14 – 18 Months	9 – 11 Years
Canine (Cuspid)	17 – 23 Months	9 – 12 Years
Lateral Incisor	10 – 16 Months	7 – 8 Years
Central Incisor	6 – 10 Months	6 – 7 Years

MY CHILD'S PERMANENT TEETH

The following chart shows when permanent teeth emerge. Record when your child's permanent teeth emerge.

UPPER TEETH	WHEN TOOTH EMERGES	MY CHILD'S TEETH EMERGED: *RIGHT SIDE*	*LEFT SIDE*
Central Incisor	7 – 8 Years		
Lateral Incisor	8 – 9 Years		
Canine (Cuspid)	11 – 12 Years		
First Premolar Molar (First Bicuspid)	10 – 11 Years		
Second Molar (Second Bicuspid)	10 – 12 Years		
First Molar	6 – 7 Years		
Second Molar	12 – 13 Years		
Third Molar (Wisdom Tooth)	17 – 21 Years		

LOWER TEETH	WHEN TOOTH EMERGES	MY CHILD'S TEETH EMERGED: *RIGHT SIDE*	*LEFT SIDE*
Third Molar (Wisdom Tooth)	17 – 21 Years		
Second Molar	11 – 13 Years		
First Molar	6 – 7 Years		
Second Premolar (Second Bicuspid)	11 – 12 Years		
First Premolar (First Bicuspid)	10 – 12 Years		
Canine (Cuspid)	9 – 10 Years		
Lateral Incisor	7 – 8 Years		
Central Incisor	6 – 7 Years		



MEDICATION LOG

Pharmacy:_____ Phone: _____

Date Started:	**Date Stopped:**	**Medication:**	**To Treat (condition):**	**Dose/Route:**	**Time Given:**	**Prescribed By:**	Side Effects:

ALLERGIC REACTION TRACKING FORM

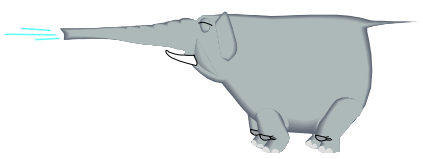
Date:	Allergen:	Reaction:	Anecdote (w/Dosage):

MY CHILD'S ALLERGIES

Food Allergies:

Medication Allergies:

Other Allergies (cats, dogs, dust, grass, etc.)



IMMUNIZATIONS

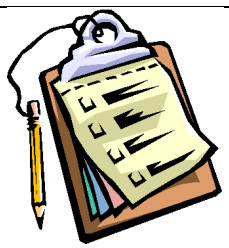
2010 CDC Immunization Program
For the best schedule, consult your child's physician or other health care professional.

Child's Age	Vaccine & Dose	Protects Against…	Vaccination Date
At Birth	Hepatitis B Dose 1 of 3	Hepatitis B virus (chronic inflammation of the liver, life-long complication)	
1 to 2 Months	Hepatitis B Dose 2 of 3	Hepatitis B virus (chronic inflammation of the liver, life-long complication)	
2 Months *(Part of Well-Baby Visit)*	DTaP Dose 1 of 5 *(*Also known as TDaP)*	Diptheria, tetanus and pertussis (whooping cough)	
	Hib Dose 1 of 4	Infections of the blood, brain, joints or lungs (pneumonia)	
	Polio (IPV) Dose 1 of 4	Polio	
	Pneumococcal conjugate (PCV7) Dose 1 of 4	Infections of the blood, brain, joints or lungs (pneumonia)	
	Rotavirus Dose 1 of 3	Rotavirus diarrhea (and vomiting)	
4 Months *(Part of Well-Baby Visit)*	DTaP Dose 2 of 5 *(*Also known as TDaP)*	Diptheria, tetanus and pertussis (whooping cough)	
	Hib Dose 2 of 4	Infections of the blood, brain, joints or lungs (pneumonia)	
	Polio (IPV) Dose 2 of 4	Polio	
	Pneumococcal conjugate (PCV7) Dose 2 of 4	Infections of the blood, brain, joints or lungs (pneumonia)	
	Rotavirus Dose 2 of 3	Rotavirus diarrhea (and vomiting)	
6 Months *(Part of Well-Baby Visit)*	DTaP Dose 3 of 5 *(*Also known as TDaP)*	Diptheria, tetanus and pertussis (whooping cough)	
	Hib Dose 3 of 4	Infections of the blood, brain, joints or lungs (pneumonia)	
	Pneumococcal conjugate (PCV7) Dose 3 of 4	Infections of the blood, brain, joints or lungs (pneumonia)	
	Rotavirus Dose 3 of 3	Rotavirus diarrhea (and vomiting)	
6 – 18 Months	Hepatitis B Dose 3 of 3	Hepatitis B virus (chronic inflammation of the liver, life-long complication)	
	Polio (IPV) Dose 3 of 4	Polio	
6 Months or Older	Influenza Dose 1 of 2	Flu and complications	
	Influenza Dose 2 of 2	Flu and complications	

12 – 15 Months	Hib Dose 4 of 4	Infections of the blood, brain, joints or lungs (pneumonia)	
	Pneumococcal conjugate (PCV7) Dose 4 of 4	Infections of the blood, brain, joints or lungs (pneumonia)	
	MMR Dose 1 of 2	Measles, mumps and rubella (German Measles)	
	Varicella Dose 1 of 2	Chickenpox	
12 – 23 Months	Hepatitis A Dose 1 of 2	Hepatitis A virus (inflammation of the liver)	
15 – 18 Months	DTaP Dose 4 of 5 *(*Also known as TDaP)*	Diptheria, tetanus and pertussis (whooping cough)	
18 Months or Older	Hepatitis A Dose 2 of 2 *(*Follows 6 months after Dose 1)*	Hepatitis A virus (inflammation of the liver)	
4 – 6 Years	DTaP Dose 5 of 5 *(*Also known as TDaP)*	Diptheria, tetanus and pertussis (whooping cough)	
	Polio (IPV) Dose 4 of 4	Polio	
	MMR Dose 2 of 2	Measles, mumps and rubella (German Measles)	
	Varicella Dose 2 of 2	Chickenpox	
11 to 12 Years	DTaP *(*Also known as TDaP)*	Diptheria, tetanus and pertussis (whooping cough)	
	MCV4*	Infections of the blood, brain, joints or lungs (pneumonia)	
	HPV Dose 1 of 3	Human Papillomavirus *(Females only)*	
	HPV Dose 2 of 3	Human Papillomavirus *(Females only)*	
	HPV Dose 3 of 3	Human Papillomavirus *(Females only)*	
Additional Vaccines		Revaccination is not necessary for everyone. Consult your physician.	

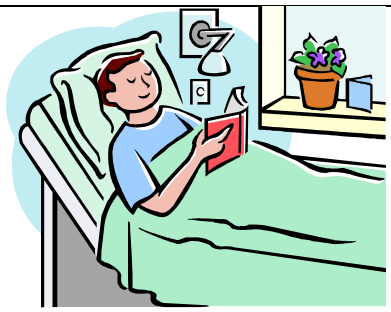
TESTS / X-RAYS / LABS

Date:	Type of Test:	Location of Test:	Results:



EMERGENCY DEPARTMENT (ROOM) VISITS / HOSPITALIZATIONS

DATE:	HOSPITAL:	REASON:	OUTCOME:



MY CHILD'S
EMERGENCY MEDICAL CARE PLAN

If your child has frequent emergency issues, consider putting together a plan with your medical home which states how issues are to be handled. Issues to address in this emergency medical plan may be:

- **Response time**
- **How to get a hold of your doctor after hours**
- **Flag child's folder to identify 'Special Needs Child'**
- **Specific support staff to contact, etc.**

EQUIPMENT LOG

Keep an ongoing record of the equipment that your child uses (such as a wheelchair, communication systems, etc.). Draw a single line through or use a highlighter to line out equipment that your child no longer uses so it is easy to spot current information.

Date:	Equipment:	Model #:	Serial #:
Vendor Name:		Vendor Phone:	____ Rent ____ Own
Financially Responsible Agency:		Other Information:	
Date:	Equipment:	Model #:	Serial #:
Vendor Name:		Vendor Phone:	____ Rent ____ Own
Financially Responsible Agency:		Other Information:	
Date:	Equipment:	Model #:	Serial #:
Vendor Name:		Vendor Phone:	____ Rent ____ Own
Financially Responsible Agency:		Other Information:	
Date:	Equipment:	Model #:	Serial #:
Vendor Name:		Vendor Phone:	____ Rent ____ Own
Financially Responsible Agency:		Other Information:	
Date:	Equipment:	Model #:	Serial #:
Vendor Name:		Vendor Phone:	____ Rent ____ Own
Financially Responsible Agency:		Other Information:	
Date:	Equipment:	Model #:	Serial #:
Vendor Name:		Vendor Phone:	____ Rent ____ Own
Financially Responsible Agency:		Other Information:	
Date:	Equipment:	Model #:	Serial #:
Vendor Name:		Vendor Phone:	____ Rent ____ Own
Financially Responsible Agency:		Other Information:	
Date:	Equipment:	Model #:	Serial #:
Vendor Name:		Vendor Phone:	____ Rent ____ Own
Financially Responsible Agency:		Other Information:	

NOTES TO TAKE TO THE DOCTOR

This is a form to help you prepare for upcoming visits with your child's doctor (health care provider) and to keep notes about the appointment.

Date of Appointment:

Provider's Name: Phone:

BEFORE THE VISIT

Issues or concerns to discuss with doctor:

What do you hope will happen at this appointment?

Follow-up tests / appointments:

Referrals required or forms to be signed:

Information / records to take to doctor:

PROGRAM PLANS FOR MY CHILD

(Birth to 3 years old)

Notes to Take to the Individual Family Service Plan (IFSP)

My Child's IFSP

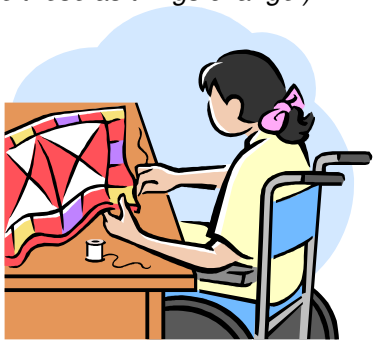
IFSP Issues / Resolution Log

Notes / Issues for Review at the Next IFSP Meeting

** A program plan is any plan that may be used to provide services for my child. This may include:

- Individual Family Service Plan (IFSP) and periodic updates.
- Speech, physical or occupational therapy plan and periodic updates.
- Psychosocial counseling or treatment care plan and periodic updates.
- Plan of Care and yearly updates through programs such as:
  - Community Alternative Program for Children (CAP-C)
  - Community Alternatives Program for Mentally Retarded / Developmentally Disabled (CAP MR/DD)

*(** Remind your child's care providers to update these as things change.)*



NOTES TO TAKE TO THE INDIVIDUAL FAMILY SERVICES PLAN (IFSP)

This is a form to help you prepare for the Individualized Family Service Plan (IFSP) meeting. The IFSP is the plan for your child's and family's support plan and services to be provided.

What are your main concerns about your child?

What are your child's strengths?

In order to put together a plan that is tailored to your child, rather than your child's diagnosis, please describe your child.

What is your child's diagnosis or qualifying condition?

Who diagnosed your child?

Who would you like to be at your IFSP?

What support does your family need? What services does your child need?

MY CHILD'S IFSP

(Insert a copy of your child's current IFSP)

IFSP ISSUES / RESOLUTION LOG

Date: Who was contacted:

Phone #:

Description of Issue:

Resolution:

NOTES / ISSUES FOR REVIEW AT THE NEXT IFSP MEETING

PROGRAM PLANS FOR MY CHILD

(3 – 5 years old)

Notes to Take to the Individual Educational Plan (IEP)

My Child's IEP

IEP Issues / Resolution Log

Notes / Issues for Review at the Next IEP Meeting

** A program plan is any plan that may be used to provide services for my child. This may include:

- Individual Education Plan (IEP) and periodic updates.
- Speech, physical or occupational therapy plan and periodic updates.
- Psychosocial counseling or treatment care plan and periodic updates.
- Plan of Care and yearly updates through programs such as:
  - Community Alternative Program for Children (CAP-C)
  - Community Alternatives Program for Mentally Retarded / Developmentally Disabled (CAP MR/DD)
- Plan of Care through Local Management Entity (LME) - Western Highlands:
  - Person Centered Plan and yearly updates
  - Continued Needs Review

*(** Remind your child's care providers to update these as things change.)*

NOTES TO TAKE TO THE INDIVIDUAL EDUCATION PLAN (IEP)

This is a form to help you prepare for the Individualized Education Program (IEP). The term IEP is used to describe the plan for your child's education and the services provided through the school system. The meeting where the plan is created is called an IEP.

What are your main concerns about your child?

What are your child's strengths?

In order to put together a plan that is tailored to your child, rather than your child's diagnosis, please describe your child.

What is your child's diagnosis or qualifying condition?

Who diagnosed your child?

Who would you like to be at your IEP?

What type of school setting and support services do you believe your child needs?

MY CHILD'S IEP

(Insert a copy of your child's current IEP)

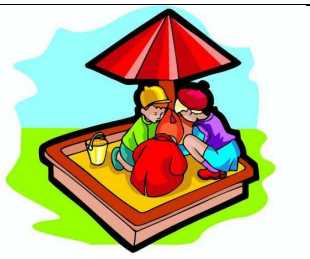
IEP ISSUES / RESOLUTION LOG

Date:	Who was contacted:
	Phone #:

Description of Issue:

Resolution:

NOTES / ISSUES FOR REVIEW AT THE NEXT IEP MEETING



PROGRAM PLANS FOR MY CHILD

(School Age K-Transition)

Notes to Take to the Individual Educational Plan (IEP)

My Child's IEP

IEP Issues / Resolution Log

Notes / Issues for Review at the Next IEP Meeting

School Information

** A program plan is any plan that may be used to provide services for my child. This may include:

- Individual Education Plan (IEP) and periodic updates.
- Transition Plan (to be developed at age 14).
- Speech, physical or occupational therapy plan and periodic updates.
- Psychosocial counseling or treatment care plan and periodic updates.
- Plan of Care and yearly updates through programs such as:
  - Community Alternative Program for Children (CAP-C)
  - Community Alternatives Program for Mentally Retarded / Developmentally Disabled (CAP MR/DD)
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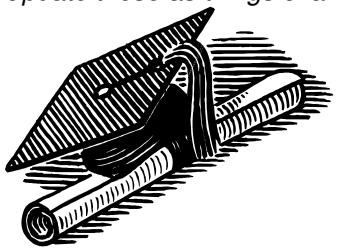
  - Person Centered Plan and yearly updates
  - Continued Needs Review

*(** Remind your child's care providers to update these as things change.)*



NOTES TO TAKE TO THE INDIVIDUAL EDUCATION PLAN (IEP) MEETING

This is a form to help you prepare for the Individualized Education Program (IEP). The term IEP is used to describe the plan for your child's education and the services provided through the school system. The meeting where the plan is created is called an IEP.

What are your main concerns about your child?

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In order to put together a plan that is tailored to your child, rather than your child's diagnosis, please describe your child.

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Who diagnosed your child?

Who would you like to be at your IEP?

What type of school setting and support services do you believe your child needs?

MY CHILD'S IEP

(Insert a copy of your child's current IEP)

IEP ISSUES / RESOLUTION LOG

Date:	Who was contacted:
	Phone #:

Description of Issue:

Resolution:

NOTES / ISSUES FOR REVIEW AT THE NEXT IEP MEETING

SCHOOL INFORMATION

(KINDERGARTEN THROUGH TRANSITION YEARS)

Preschool

School:	Address:
Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:
ST/PT/OT Name:	ST/PT/OT Phone:
Other:	

Preschool

School:	Address:
Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:
ST/PT/OT Name:	ST/PT/OT Phone:
Other:	

Kindergarten

School:	Address:
Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:
ST/PT/OT Name:	ST/PT/OT Phone:
Other:	

1st Grade

School:	Address:
Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:
ST/PT/OT Name:	ST/PT/OT Phone:
Other:	

2nd Grade

School:	Address:
Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:
ST/PT/OT Name:	ST/PT/OT Phone:
Other:	

3rd Grade

School:	Address:
Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:
ST/PT/OT Name:	ST/PT/OT Phone:

Other:

4th Grade

School:	Address:
Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:
ST/PT/OT Name:	ST/PT/OT Phone:

Other:

5th Grade

School:	Address:
Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:
ST/PT/OT Name:	ST/PT/OT Phone:

Other:

6th Grade

School:	Address:
Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:
ST/PT/OT Name:	ST/PT/OT Phone:

Other:

7th Grade

School:	Address:
Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:
ST/PT/OT Name:	ST/PT/OT Phone:

Other:

8th Grade

School:	Address:

Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:
ST/PT/OT Name:	ST/PT/OT Phone:

Other:

9th Grade

School:	Address:
Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:
ST/PT/OT Name:	ST/PT/OT Phone:

Other:

10th Grade

School:	Address:
Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:
ST/PT/OT Name:	ST/PT/OT Phone:

Other:

11th Grade

School:	Address:
Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:
ST/PT/OT Name:	ST/PT/OT Phone:

Other:

12th Grade

School:	Address:
Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:
ST/PT/OT Name:	ST/PT/OT Phone:

Other:

Transition Year

School:	Address:
Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:

ST/PT/OT Name:	ST/PT/OT Phone:
Other:	

Transition Year

School:	Address:
Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:
ST/PT/OT Name:	ST/PT/OT Phone:
Other:	

Transition Year

School:	Address:
Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:
ST/PT/OT Name:	ST/PT/OT Phone:
Other:	

Transition Year

School:	Address:
Principal:	Principal Phone:
Teacher/ Aide/ Inclusion Specialist:	Teacher/ Aide/ Inclusion Specialist Phone:
ST/PT/OT Name:	ST/PT/OT Phone:
Other:	

ADDITIONAL RESOURCES & FORMS

Alphabet Soup Acronym Index

Questions / Concerns Form for Care Providers

Legal Papers

Western Highlands – How to Get Services

Helpful Websites

Make a Calendar Form

Diet Tracking Form

Care Schedule Form (a.m. & p.m.)

Vision for the Future Form

Appointment Log

Sign-In Log

ALPHABET SOUP ACRONYM INDEX

The following index lists acronyms used by professionals who work with families.

ADA	Americans with Disabilities Act
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
AIDS	Acquired Immune Deficiency Syndrome
ARC	The ARC: Advocates for the Rights of Citizens with Developmental Disabilities and their Families
ARNP	Advanced Registered Nurse Practitioner
BIA	Bureau of Indian Affairs
BD	Behaviorally Disabled
CAP-C	Community Alternatives Program for Children
CAP-MR/DD	Community Alternatives Program for Mentally Retarded/Developmentally Disabled Individuals
CD	Communication Disorders
CDS	Communication Disorders Specialist
CFR	Code of Federal Regulations
CHDD	Center on Human Development and Disability at the University of Washington
CHRMC	Children's Hospital and Regional Medical Center
CP	Cerebral Palsy
CPS	Child Protective Services
CSHCN	Children with Special Health Care Needs
CSO	Community Service Office, DSHS
DCFS	Division of Children and Family Services
DD	Developmentally Disabled
DDD	Division of Developmental Disabilities, DSHS
DDPC	Developmental Disabilities Planning Council
DH	Developmentally Handicapped
DMH	Division of Mental Health
DOH	Department of Health
DSB	Department of Services for the Blind
DSHS	Department of Social and Health Services
DVR	Division of Vocational Rehabilitation
ECDAW	Early Childhood Development Association of Washington
ECEAP	Early Childhood Education and Assistance Program
ED	Emotionally Disturbed
EEG	Electroencephalogram
EEU	Experimental Education Unit, CHDD
EFMP	Exceptional Family Member Program (helps military families locate to areas with services)
EKG	Electrocardiogram
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
ESD	Educational Service District
FAPE	Free Appropriate Public Education
FRC	Family Resources Coordinator
HHS	Health and Human Services
HI	Health Impaired or Hearing Impaired
HMO	Health Maintenance Organization
HO	Healthy Options, DSHS, Medicaid Managed Care Program
HOH	Hard of Hearing
ICC	Interagency Coordinating Council; county ICC and state ICC.
IDEA	Individuals with Disabilities Education Act
IEP	Individual Education Plan
IFSP	Individual Family Service Plan

I & R	Information and Referral
ISP	Individual Service Plan
LD	Learning Disabled
LDA	Learning Disabilities Association
LEA	Local Education Agency
LICWAC	Local Indian Child Welfare Advocacy Board
LRE	Least Restrictive Environment
MCH	Maternal and Child Health
MD	Medical Doctor
MDT	Multi-Disciplinary Team
MH	Multiply Handicapped
MR	Mentally Retarded
MR/DD	Mentally Retarded/Developmentally Disabled Individuals
MS	Multiple Sclerosis
NICU	Neonatal Intensive Care Unit
NORD	National Association of Rare Disorders
OCR	Office of Civil Rights
OFM	Office of Financial Management
OI	Orthopedically Impaired
OSEP	Office of Special Education Programs
OSERS	Office of Special Education and Rehabilitation Services
OSPI	Office of Superintendent of Public Instruction
OT	Occupational Therapy/Therapist
OTR	Licensed and Registered Occupational Therapist
PAVE	Parents Are Vital in Education
P & A	Protection and Advocacy
PHN	Public Health Nurse
PL	Public Law
PT	Physical Therapy/Therapist
PTA	Parent Teacher Association
RCW	Revised Code of Washington (state law)
RN	Registered Nurse
RPT	Registered Physical Therapist
SBD	Seriously Behaviorally Disabled
SEA	State Education Agency
SEAC	Special Education Advisory Council
SEPAC	Special Education Parent/Professional Advisory Council
SLD	Specific Learning Disability
SSA	Social Security Administration
SSI	Social Security Income
STOMP	Specialized Training of Military Parents
SW	Social Work/Worker
TANF	Temporary Assistance to Needy Families
TAPP	Technical Assistance for Parents and Professionals
TASH	The Association for Persons with Severe Handicaps
TBI	Traumatic Brain Injury
TDD	Telecommunication Device for the Deaf
TRICARE	U.S. Department of Defense Health Care System
TTY	Telecommunication Device for Deaf, Hearing Impaired, and Speech Impaired Persons
VI	Visually Impaired
WAC	Washington Administrative Code
WACD	Washington Association for Citizens with Disabilities
WIC	Women, Infants and Children Supplemental Food Program
WSMC	Washington State Migrant Council
WSSB	Washington State School for the Blind

This list was adapted from and used with permission of PAVE.

QUESTIONS / CONCERNS FORM FOR CARE PROVIDERS

(This form may help to remember what to ask any of my child's care providers.)

LEGAL PAPERS

(Insert copies of important legal papers, such as:
custody, guardianship, or advanced directives forms.)

WESTERN HIGHLANDS

HELPFUL WEBSITES

Local Resources

Asheville City Schools
www.ashevillecityschools.net

Buncombe Co. Schools
www.buncombe.k12.nc.us

www.ecac-parentcenter.org/education/health.htm NC Family to Family Health Information Center (HIC): A state-wide resource providing health information and support to families with children who have special health care needs. Materials also available about transitioning from pediatric to adult health care.

www.FamilySupportNetworkWNC.org Parent-to-parent support, educational resources through workshops, lending library and a detailed listing of community resources for raising a child with special needs in Buncombe, Henderson, Madison and Transylvania counties. Click on "Resources" and then under "Helpful Links", click on "Community Resource Guide".

www.FIRSTwnc.org A community benefit organization dedicated to providing information, education, support and advocacy to persons with disabilities, their family and the community. F.I.R.S.T. provides direct support and education programs to families.

www.WesternHighlands.org Serves as the Local Management Entity (LME) for Buncombe and surrounding counties. They are local government area authorities responsible for managing, coordinating, facilitating and monitoring the provision of mental health, developmental disabilities and substance abuse services in the catchment area served.

Statewide Resources

http://www.ncdhhs.gov/dma/medicaid/capchildren.htm Medicaid is a health insurance program for low-income individuals and families who cannot afford health care costs. Medicaid serves low-income parents, children, seniors, and people with disabilities. The Community Alternatives Program for Children (CAP/C - also known as the Katie Beckett waiver) provides home and community based services to medically fragile children who, because of their medical needs, are at risk for institutionalization in a nursing home.

http://www.dpi.state.nc.us/ec Exceptional Children Division assures that students with disabilities develop mentally, physically, emotionally, and vocationally through the provision of an appropriate individualized education in the least restrictive environment. Their website contains helpful parent resources, procedural safeguards, and parent rights handouts for download.

http://www.ncei.org/ei/itp/cdsa.html Children's Developmental Service Agency provides early intervention services to eligible children from birth to age three and their families.

http://www.ncdhhs.gov/dph/wch/families/helplines.htm NC Department of Health and Human Services: Children with Special Health Care Needs Helpline – for those living with, care for and concerned about a child with special health care needs. Information about potential health care programs and funding resources in NC.

National Resources

http://www.aap.org/ American Academy of Pediatrics

www.HealthyTransitionsNY.org For youth with developmental disabilities ages 14-25, family caregivers, service coordinators, and health care providers. It teaches skills and provides tools for care coordination, keeping a health summary, and setting priorities during the transition process. It features video vignettes that demonstrate health transition skills and interactive tools that foster self determination and collaboration.

http://www.medicalhomeinfo.org/ Provides resources for health professionals, families, and everyone interested in creating a family-centered medical home for all children and youth.

www.growthcharts.com Height and Weight Charts for Children with Down Syndrome

Other versions of care notebooks and helpful forms can be downloaded at:

www.cshcn.org Information on care notebooks & emergency preparedness
http://www.aap.org/
hrtw.org
www.FullLifeAhead.org
specialchildren.about.com/od/medicalissues/qt/notebook.htm

MAKE-A-CALENDAR FORM Month_____ Year _____

SUNDAY	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**SATURDAY**

DIET TRACKING FORM

DATE	**SUNDAY**	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**SATURDAY**
Tube Feeding							
Breakfast							
Lunch							
Dinner							
Snacks							
Notes							

CARE SCHEDULE

TIME	CARE
Morning	
Afternoon	

CARE SCHEDULE

TIME	CARE
Evening	
Night	

VISION FOR THE FUTURE FORM

Date:

Ideas for the future of my child (Employment, Housing, Dreams, etc.):

Resources to make my child's dreams come true:

APPOINTMENT LOG

Date:	Care Provider:	Reason for Appointment:	Care Provided:	Next Appointment Date / Time

SIGN-IN LOG

Date:	Name of Care Provider:	Reason for Appointment:	Type of Contact:	Result: