



This Binder Belongs to:

My Care Binder

**UC DAVIS
HEALTH**

**CHILDREN'S
HOSPITAL**

Children's Miracle Network Hospitals member 

My Care Binder



“**My care binder**” is a tool for families who have children with special healthcare needs. Use your “Care Binder” to:

- Keep track of your child’s medications
- List phone numbers of healthcare providers and resources
- Get ready for appointments
- Share information with your child’s healthcare providers

The “Care Binder” is a notebook where you can organize health information, reports, doctors’ visits and written handouts

To set up your “care binder”

- STEP 1:** **Decide what you want to keep in the “Care Binder.”** What information do you look up most often? What do people who care for your child need to know about your child?
- STEP 2:** **Gather any information you already have** – such as reports, hospital stays, and test results
- STEP 3:** **Choose pages from the “Care Binder”** packet that you like
- STEP 4:** **Put together your “Care Binder”** – you can use tabbed dividers or pocket dividers to separate the pages. Make it easy to find the information you need.

You can print extra “Care Binder” pages from the UC Davis Children’s Hospital website: www.ucdmc.ucdavis.edu/children/patients_family_resources/Patient_and_Family_Education_A_to_Z/index.html

You can download more pages for your “Care Binder” from these websites:

Center for Children with Special Needs, Seattle Children’s, and Washington State Department of Health, Children with Special Health Care Needs Program: <http://cshcn.org/planning-record-keeping/care-notebook>

National Center for Medical Home Information, American Academy of Pediatrics: www.medicalhomeinfo.org/for_families/care_notebook

My Daily Schedule: _____

Time	Care/Activity
 Morning	
Afternoon	
Evening	
 Night	



Calendar

MONTH

YEAR

UC DAVIS
HEALTH

CHILDREN'S
HOSPITAL

Children's Miracle Network Hospitals member 

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY



Calendar

MONTH

YEAR

UC DAVIS
HEALTH

CHILDREN'S
HOSPITAL

Children's Miracle Network Hospitals member 

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Getting to Know Me

My Name:	Nickname:
Date of Birth:	Today's Date:
A Little About Me:	
My Strengths: (things that are easy for me)	
My Challenges: (communication, feeding, learning, mobility, social, energy, behavior)	
My Life in the Community: (school, childcare, place of worship, my favorite places)	
My Home and Family Information:	
My Diagnosis (Diagnoses):	
My Overall Health:	
My Prior Surgeries, Procedures, Lab/Diagnostic Studies:	

Getting to Know Me

My Name:	Nickname:
Date of Birth:	Today's Date:
My Current Medicines/Doses:	
My Allergies:	
Things to Avoid: (food, activities, and procedures)	
My Equipment/Assistive Technology: (braces/orthotics, walker, wheelchair, communication device, home O2, insulin pump, nebulizer, suction)	
Other Things I'd Like You to Know About Me:	
Ways You Can be Helpful to Me:	

Diet Tracking Form



**UC DAVIS
HEALTH**

**CHILDREN'S
HOSPITAL**

Children's Miracle Network Hospitals member

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

Infant Bottle / GT Feeding Schedule



Bottle Feeding



G-Tube Feeding



Diapers



Medications

Feeding Times

Remember to add _____ mLs of milk to bag to prime the tubing. This is not part of the feeding.

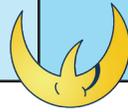


_____ am

_____ am

_____ pm

_____ pm



_____ pm

_____ pm

_____ pm

Add _____ mls to bag and set pump to _____ mls per hour

Add _____ mls to bag and set pump to _____ mls per hour



Family Support Resources

Medical Supply Company: _____

Contact Person: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

Medical Supply Company: _____

Contact Person: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

Home Care Nursing (Home Health, Public Health, Shift/Respite): _____

Contact Person: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

Regional Center/other developmental support organization: _____

Contact Person: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

Other: _____

Contact Person: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

Other: _____

Contact Person: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

In Case of Emergency

Updated: _____

CHILD'S INFORMATION

Name:		Allergies:
Birth Date:	Primary Language/Communication:	
Home Address:		
Parents/Guardians:		Relationship:
Home #:		Other #'s:
Diagnosis:		

Medications	Dose	Medications	Dose

Emergency Contact:	Relationship:	Phone #'s:
--------------------	---------------	------------

PHYSICIAN'S INFORMATION

Primary Doctor:	Phone:	Fax:
Specialist:	Phone:	Fax:
Specialist:	Phone:	Fax:

Insurance: _____

PHARMACY INFORMATION

Name:	
Address:	Phone:

OTHER/TUBES/DEVICES

Most important things to know about my child in an emergency:

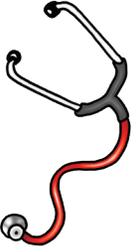
Emergency Contacts

Name:	Date of birth:
Address:	Phone Numbers:
Medical Record Number:	Insurance:
Preferred Hospital:	Subscriber Info:
Parent/Guardian Info Name:	Parent/Guardian Info Name:
Phone:	Phone:
Emergency Contact Info Name:	Emergency Contact Info Name:
Relation:	Relation:
Phone:	Phone:
Doctor Contact Information	
Primary Care Doctor:	Primary Care Doctor:
Phone Number:	Specialty:
	Phone Number:
Specialty Care Doctor:	Specialty Care Doctor:
Specialty:	Specialty:
Phone Number:	Phone Number:
Specialty Care Doctor:	Specialty Care Doctor:
Specialty:	Specialty:
Phone Number:	Phone Number:

What's the Plan?

Child's name: _____

Questions/Concerns:	Date:	Date:	Date:
What do I want to talk about today? <ul style="list-style-type: none"> • What's new? • Concerns? 			
What do I hope to have happen? <ul style="list-style-type: none"> • Today • From the doctor • For me (the patient) to do 			
Next Steps? What needs to be done? <ul style="list-style-type: none"> • Medicine changes • Labs • Equipment 			
Who will do this? <ul style="list-style-type: none"> • Patient • Parents • Doctors • Nurses 			
By When? (time frame)			
How will we follow-up?			



CHILDREN'S HOSPITAL

UC DAVIS HEALTH