



RECORD KEEPING & PERSONAL CARE GUIDE

A COMPREHENSIVE COLLECTION OF FORMS INCLUDING:
MEDICAL INFORMATION • PERSONAL CONTACT NUMBERS • EMERGENCY INFORMATION
INSURANCE INFORMATION • CARE GIVER'S INFORMATION • ORGANIZATIONAL TOOLS



TABLE OF CONTENTS

Why Keep Records.....	3
Personal Medical Information.....	4
Insurance Information.....	7
Community Resources Information.....	9
Care-Giver's Guide.....	11
In Case of Emergency.....	18
Grocery List Template.....	21
Phone List Template.....	22
Personal Budget Worksheet.....	23



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KEEPING VITAL RECORDS IS ESSENTIAL

Nothing is more important to your personal welfare than developing and maintaining a complete, up-to-date record-keeping system.

Record-keeping is essential. It's important for emergency hospital visits, insurance claims, respite care providers, or for documenting events and/or contacts about your medical needs. There is no other way to be prepared for events where current information is needed. Like it or not, understand it or not, there are forms you have to fill out everywhere you go! Having basic information on hand makes it manageable. It's also a way of noting family history, developmental landmarks, and the next logical steps which may help identify delays or detect problems.

PERSONAL, MEDICAL & INSURANCE INFORMATION

Below is a list of some of the important information that must be kept. It is not a complete list – that depends entirely on your disability or chronic illness. You may also decide to provide this information to other members of your family. This includes such personally identifiable information as:

Personal

- Birth certificates;
- Parent or guardian information;
- Location of wills and/or trusts;
- Daily care schedule;
- Grocery list;
- Budget information;
- Emergency contacts;

Medical

- Initial diagnosis;
- Health history;
- Physicians and other medical specialists;
- Medication and seizure logs;
- Daily care schedule;
- Immunization records;
- Office visits;
- Hospitalization information;
- Emergency contacts;

Insurance

- Health and life insurance information;

MEDICAL BILLS & INSURANCE CLAIMS

Keep all information needed to fill out forms. Keep a supply of blank claim forms, envelopes and stamps. Maintain files on all insurance company correspondence or claims. For tax purposes, keep an accurate account of what your policy covered and your out-of-pocket expenses.

EVALUATIONS, REPORTS & RECORDS

Keep copies or records of all correspondence (written and verbal) with service providers, medical support specialists and other professionals your child comes in contact with, along with all reports, records and other documents. They may contain important information in those cases where discrepancies may arise concerning your needs and/or program. Be certain copies of all medical reports are sent to your physician.

GETTING ORGANIZED

How your record-keeping system is organized is up to you. Just be certain it allows quick, easy access to all the information needed under any set of circumstance. Here are some recommendations. Purchase a three-ring binder with pockets for organizing and holding reports, etc. Insert blank pages and/or forms for recording your own information. Keep all current information in the notebook. Keep older information in a permanent, but portable, filing system. Purchase a small, portable file and file folders. File information using separate file folders for each category. To prevent record keeping from becoming a chore that keeps you from spending time with the important people in your life, organize early and in a manner that best suits your individual needs.

PERSONAL MEDICAL INFORMATION

Today's Date _____

PERSONAL INFORMATION

Name _____ Age _____ Date of Birth _____

Birthplace _____ Sex (M) (F) Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Father/Legal Guardian _____ Social Security Number _____

Address *(if different)* _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Mother/Legal Guardian _____ Social Security Number _____

Address *(if different)* _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Emergency Contact _____ Relationship _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

HEALTH HISTORY

Initial Diagnosis _____

Diagnosis Date _____

Other Medical Conditions/Information _____

Allergies _____

Medications _____

Assistive Devices _____

Eye and/or Hearing Devices _____

Family Physician _____

Office Address _____

City _____ State _____ Zip _____

Office Telephone (____) _____

Other Medical Specialist _____

Office Address _____

City _____ State _____ Zip _____

Office Telephone (____) _____

Other Medical Specialist _____

Office Address _____

City _____ State _____ Zip _____

Office Telephone (____) _____

Other Medical Specialist _____

Office Address _____

City _____ State _____ Zip _____

Office Telephone (____) _____

TESTS & EVALUATIONS

Conducted By _____
Office Telephone _____
Date Conducted _____
Test/Evaluation Result _____

Conducted By _____
Office Telephone _____
Date Conducted _____
Test/Evaluation Result _____

Conducted By _____
Office Telephone _____
Date Conducted _____
Test/Evaluation Result _____

Conducted By _____
Office Telephone _____
Date Conducted _____
Test/Evaluation Result _____

Conducted By _____
Office Telephone _____
Date Conducted _____
Test/Evaluation Result _____

MEDICAL OFFICE VISITS

Date _____
Reason for Visit _____
Physician/Specialist _____
Clinic Name _____
Office Telephone _____
Test Performed _____
Results & Treatment _____

Date _____
Reason for Visit _____
Physician/Specialist _____
Clinic Name _____
Office Telephone _____
Test Performed _____
Results & Treatment _____

Date _____
Reason for Visit _____
Physician/Specialist _____
Clinic Name _____
Office Telephone _____
Test Performed _____
Results & Treatment _____

INSURANCE INFORMATION

Today's Date _____

PERSONAL INFORMATION

Name _____ Age _____ Date of Birth _____

Birthplace _____ Sex (M) (F) Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Father/Legal Guardian _____ Social Security Number _____

Address *(if different)* _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Mother/Legal Guardian _____ Social Security Number _____

Address *(if different)* _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Emergency Contact _____ Relationship _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

INSURANCE COMPANY INFORMATION

Primary Insurance Carrier _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Policy Number _____ Group Number _____

Agent's Name _____

Agent's Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____

Secondary Insurance Carrier _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Policy Number _____ Group Number _____

Agent's Name _____

Agent's Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____

Medicaid Number _____ State _____ Date of Eligibility _____

COMMUNITY RESOURCES INFORMATION

Today's Date _____

PERSONAL INFORMATION

Name _____ Age _____ Date of Birth _____

Birthplace _____ Sex (M) (F) Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Father/Legal Guardian _____ Social Security Number _____

Address *(if different)* _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Mother/Legal Guardian _____ Social Security Number _____

Address *(if different)* _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Emergency Contact _____ Relationship _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

COMMUNITY SERVICES (NONPROFIT)

Name of Agency/Organization _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Contact Person _____

Description of Services _____

Name of Agency/Organization _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Contact Person _____

Description of Services _____

COUNTY SERVICES

Name of Agency/Organization _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Contact Person _____

Description of Services _____

Name of Agency/Organization _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Contact Person _____

Description of Services _____

STATE AGENCY/ORGANIZATION

Name of Agency/Organization _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Contact Person _____

Description of Services _____

Name of Agency/Organization _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Contact Person _____

Description of Services _____

OTHER AGENCY/ORGANIZATION

Name of Agency/Organization _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Contact Person _____

Description of Services _____

Name of Agency/Organization _____

Office Address _____ City _____ State _____ Zip _____

Office Telephone (____) _____ Contact Person _____

Description of Services _____

CARE-GIVER'S GUIDE

Today's Date _____

PERSONAL INFORMATION

Child's Name _____ Age _____ Date of Birth _____

Birthplace _____ Sex (M) (F) Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Father/Legal Guardian _____ Social Security Number _____

Address *(if different)* _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Mother/Legal Guardian _____ Social Security Number _____

Address *(if different)* _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Emergency Contact _____ Relationship _____

Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

EMERGENCY CONTACTS/NUMBERS

Police, Fire & Ambulance – 911

Poison Control Center Telephone (____) _____

Family Physician _____ Telephone (____) _____

Pharmacy _____ Telephone (____) _____

Insurance Agency _____

Contact Person _____ Telephone (____) _____

Preferred Hospital _____ Telephone (____) _____

Neighbor _____ Telephone (____) _____

Neighbor _____ Telephone (____) _____

Relative or Close Friend _____

Relationship _____ Telephone (____) _____

Relative or Close Friend _____

Relationship _____ Telephone (____) _____

HOUSEHOLD ROUTINE

First aid kit location _____

Who, if anyone is allowed to visit the child when the parent isn't home? _____

Is the child allowed to play outside? (Yes) (No)

If so, explain the boundaries, rules and length of time _____

Household rules providers and caregivers should follow when the parents are not home _____

CHILD'S DAILY SCHEDULE

7:00 AM _____

8:00 AM _____

9:00 AM _____

10:00 AM _____

11:00 AM _____

12:00 PM _____

1:00 PM _____

2:00 PM _____

3:00 PM _____

4:00 PM _____

5:00 PM _____

6:00 PM _____

7:00 PM _____

8:00 PM _____

9:00 PM _____

10:00 PM _____

11:00 PM _____

12:00 AM _____

1:00 AM _____

2:00 AM _____

3:00 AM _____

4:00 AM _____

5:00 AM _____

6:00 AM _____

SEIZURES

Does the child have seizures? (Yes) (No)

If so, describe in detail _____

General length of seizures _____

What procedure(s) should be followed during a seizure? (Do you want the paramedics to be called?) _____

Should seizures be recorded? (Yes) (No)

What usually occurs following a seizure? (Will the child become sleepy, cranky, etc.) _____

CHILD'S BEHAVIOR

Describe the child's normal behavior _____

Are there behaviors that are particularly challenging? _____

If so, what actions should be taken? _____

Is there a specific behavior plan for the child? If so, please describe _____

Has the child been known to wander or run away? _____

Activities that make the child happy, including toys, favorite games, etc. _____

Notes _____

Is the child verbal? (Yes) (No)

In case the child isn't verbal, how does he or she communicate? _____

Specifically, how does the child communicate the need to eat? _____

Ask to be picked up or held? _____

Express interest in playing with a specific toy or game? _____

Does the child use sign language as a form of communication? (Yes) (No)

If so, please explain how _____

How does the child communicate the following?

Hungry _____

Thirsty _____

Tired _____

Happy _____

Hot _____

Cold _____

Brother _____

Sister _____

Mother _____

Father _____

Blanket _____

Bath _____

Toilet _____

Diaper _____

Bed _____

Dog _____

Cat _____

Video _____

TV _____

Music _____

Hello _____

Goodbye _____

Car _____

Walk _____

Outside _____

Inside _____

Sad _____

Angry _____

Play with me _____

Leave me alone _____

I want more _____

I am finished _____

Please _____

Thank you _____

I'm sick _____

Other _____

CONT..:

Does the child use a specialized communication device? (Yes) (No)

If so, explain how the device is used _____

Where is it located and/or placed when not in use? _____

CHILD'S DIET

Are there foods the child likes? _____

Are there foods the child dislikes? _____

Does the child have any food allergies? If so, please list and identify symptoms _____

Does the child swallow well? (Yes) (No) Please explain _____

Does the child need assistance while eating? (Yes) (No) If yes, what type of assistance is necessary? _____

Is there a particular position or adaptive equipment necessary to assist the child during the meal? _____

Please detail the location of the child's food, eating utensils and/or adaptive equipment _____

CHILD'S BED & NAP TIMES

At what time does the child go to bed? _____

What are the child's nap time(s)? _____

Does the child sleep alone? (Yes) (No)

Is the child afraid of the dark? (Yes) (No)

Is there a special toy or blanket the child likes to sleep with? _____

Are there special positioning needs at bed time? _____

Is any special nightly routine observed? _____

Does the child usually sleep through the night? (Yes) (No) If not, explain the activities required to either induce sleep or keep the child occupied while awake. _____

IN CASE OF EMERGENCY

Today's Date _____

PERSONAL INFORMATION

Child's Name _____ Age _____ Date of Birth _____
Birthplace _____ Sex (M) (F) Social Security Number _____
Address _____ City _____ State _____ Zip _____
Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____
Height _____ Weight _____
Hair Color _____ Eye Color _____
Distinguishing Marks _____

EMERGENCY CONTACT NUMBERS

Father/Legal Guardian _____ Social Security Number _____
Address (if different) _____ City _____ State _____ Zip _____
Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Mother/Legal Guardian _____ Social Security Number _____
Address (if different) _____ City _____ State _____ Zip _____
Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Primary Emergency Contact _____ Relationship _____
Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Secondary Emergency Contact _____ Relationship _____
Home Telephone (____) _____ Work Telephone (____) _____ Cell Phone (____) _____

Primary Physician _____
Office Telephone (____) _____ Emergency Telephone (____) _____
Notes _____

Secondary Physician _____
Office Telephone (____) _____ Emergency Telephone (____) _____
Notes _____

What I want an emergency physician to know _____

PRESCRIPTION DRUGS

<i>Medication</i>	<i>Doseage</i>	<i>Frequency</i>	<i>Reason</i>

ALLERGIES

<i>Type</i>	<i>Severity</i>	<i>Frequency/Last Occurrence</i>

CHRONIC CONDITIONS

<i>Type</i>	<i>Severity</i>	<i>Notes</i>

GROCERY LIST

Make grocery shopping easier by always going with a prepared list. The following template can be copied and used again and again.

Produce

- __ Potatoes
- __ Mushrooms
- __ Onions
- __ Lettuce
- __ Tomato
- __ Carrots
- __ Broccoli
- __ Cauliflower
- __ Spinach
- __ Bananas
- __ Apples
- __ Oranges
- __ Grapes
- __ Melon
- __ Berries
- __ Lemon/Lime
- _____
- _____

Deli

- __ Deli Meats
- __ Deli Salads
- __ Deli Cheese
- _____
- _____

Snacks

- __ Cookies
- __ Crackers
- __ Graham Crackers
- __ Chips
- __ Popcorn
- _____
- _____

Breads

- __ Bread
- __ Hot Dog Buns
- __ Hamburger Buns
- __ Bagels
- __ English Muffins
- __ Croutons
- _____
- _____

Beverages

- __ Juice
- __ Kool Aid
- __ Lemonade
- __ Pop/Soda
- __ Bottled Water
- __ Chocolate Syrup
- __ Coffee
- __ Tea
- _____
- _____

Condiments

- __ BBQ Sauce
- __ Mustard
- __ Mayonnaise
- __ Pickles/Relish
- __ Ketchup
- __ Marinade
- __ Salad Dressings
- __ Jelly/Jam
- __ Peanut Butter
- __ Seasoning Packet
- _____
- _____

Canned Goods

- __ Tuna
- __ Spaghetti Sauce
- __ Pizza Sauce
- __ Tomato Products
- __ Mushrooms
- __ Soup
- __ Beans
- __ Corn
- _____
- _____

Canned Fruits

- __ Applesauce
- __ Fruit Cups
- __ Pineapple
- __ Peaches
- __ Pears
- __ Fruit Cocktail
- __ Raisins
- _____
- _____

Bakery

- __ Donuts
- __ Cake
- __ Pie
- __ Cinnamon Rolls
- __ Brownies
- __ Cookies
- _____
- _____

Dairy

- __ Milk
- __ Orange Juice
- __ Dinner Roll Dough
- __ Cookie Dough
- __ Butter/Margarine
- __ Eggs
- __ Yogurt
- __ Sliced/Shredded Cheese
- __ Cream Cheese
- __ Sour Cream
- __ Cottage Cheese
- _____
- _____

Cereals

- __ Cereal
- __ Granola Bars
- __ Oatmeal
- __ Hot Cereal
- _____
- _____

Pasta

- __ Spaghetti
- __ Mac & Cheese
- __ Lasagna Noodles
- __ Rice
- __ Noodle & Sauce Mix
- _____
- _____

Ethnic Foods

- __ Taco Mix
- __ Tortilla Shells
- __ Taco Sauce
- __ Soy Sauce
- __ Teriyaki Sauce
- _____
- _____

Meat

- __ Ground Beef
- __ Chicken
- __ Ground Turkey
- __ Beef Roast
- __ Steaks
- __ Burger Patties
- __ Pork Chops
- __ Pork Roast
- __ Bacon
- __ Hot Dogs
- __ Sausage
- __ Brats
- __ Ham
- _____
- _____

Baking

- __ Sugar
- __ Flour
- __ Pancake Mix
- __ Muffin Mix
- __ Cake/Brownie Mix
- __ Pie Crust
- __ Marshmallows
- __ Jello
- __ Pudding
- __ Pancake Syrup
- __ Honey
- __ Chocolate Chips
- _____
- _____

Health/Beauty

- __ Suntan lotion
- __ Shampoo
- __ Conditioner
- __ Deodorant
- __ Bath Soap
- __ Feminine Supplies
- __ Make-Up
- __ Toothpaste
- __ Mouthwash
- __ Lotion
- __ Band Aids
- __ Antiseptic Cream
- __ Medicines
- __ Vitamins
- _____
- _____

Frozen Foods

- __ Frozen Meats
- __ Frozen Veggies
- __ Frozen Fruits
- __ Waffles
- __ French Fries
- __ Pizza
- __ Ice Cream
- _____
- _____

Paper Goods

- __ Napkins
- __ Paper Towels
- __ Toilet Paper
- __ Tissues
- __ Paper Plates
- __ Paper Cups
- __ Plastic Bags
- __ Aluminum Foil
- __ Plastic Wrap
- __ Wax Paper
- _____
- _____

Cleaners

- __ Laundry Detergent
- __ Fabric Softener
- __ Dishwasher Soap
- __ Bleach
- __ Disinfectant
- __ Dusting Spray
- _____
- _____

Baby Items

- __ Baby Food
- __ Diapers
- __ Baby Wipes
- _____
- _____

Other

- __ Pet Food
- __ Light Bulbs
- __ Cards/Gift Wrap
- _____
- _____

PHONE LIST

IMPORTANT PHONE NUMBERS

My Home Telephone _____

My Cell Phone _____

Mother/Guardian _____

Father/Guardian _____

Primary Physician _____

Secondary Physician _____

Dentist _____

Optometrist _____

Neighbor _____

Neighbor _____

Babysitter _____

PERSONAL BUDGET WORKSHEET

INCOME

<i>Income</i>	<i>Monthly Amount</i>
Net Pay	
Second Job - Net Pay	
Investments	
Interest	
Other	
TOTAL INCOME	\$.

ROUTINE (FIXED) EXPENSES

<i>Expense</i>	<i>Monthly Amount</i>
Cable TV	
Car Payments	
Child Care	
Credit Card Payments	
Insurance (Health, Life, Property)	
Internet Service Provider	
Rent or Mortgage	
Student Loans	
Taxes	
Telephone	
Utilities	
Other	
TOTAL ROUTINE EXPENSES	\$.

VARIABLE EXPENSES

<i>Expense</i>	<i>Monthly Amount</i>
Babysitting	
Food	
Transportation (Gas, Maintenance, Parking, Taxis)	
Vacation	
Clothing (Purchases, Dry Cleaning)	
Education	
Entertainment	
Gifts (Birthdays, Holidays, Weddings)	
Hair Care, Body Care (Hair Cuts, Manicures, Tanning)	
Medication, Medical Visits, Glasses/Contacts	
Savings	
Other	
TOTAL VARIABLE EXPENSES	\$.

Total monthly fixed and variable expenses \$.
 Difference between monthly income and expenses = surplus / (deficit) \$.



IT IS THE MISSION OF THE OHIO DEVELOPMENTAL DISABILITIES COUNCIL TO CREATE CHANGE THAT IMPROVES INDEPENDENCE, PRODUCTIVITY, AND INCLUSION FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES AND THEIR FAMILIES IN COMMUNITY LIFE.

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