Support by Design
138 Reade Street
New York, NY 10013
Tel (212) 608-9661
Fax (212) 608-9660

Child's Name: _____
Today's Date:_____
Sex: Male ☐ Female ☐ Date of Birth: _____
E-Mail Address: _____

Family Information: Names and Ages

Parent(s):_____
_____
Siblings: _____
_____
_____
_____
Caregiver: _____

Contact Information:

Address: _____

Home Phone: _____

Parent 1 Work: _____

Parent 1 Cell: _____

Parent 2 Work: _____

Parent 2 Cell: _____

Caregiver Contact #: _____

Parent/Caregiver Email: _____

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Privacy Consent

I understand that, the Health Insurance and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected Health information. I understand that the information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

You have informed me of your Notice of Privacy Practices, which contains a more complete description on the uses and disclosures of my health information. I have been given the right to read and review your Notice if Privacy Practices before signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization's Privacy Officer to obtain a current copy of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations and I also understand that you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying this consent.

Patient Name (please print) _____

Signature _____ Date _____

Relationship to patient _____

If there is anyone else authorized to pick up or drop off your child, please fill out the form below:

I, _____, give permission for the following person(s) to pick up and/or drop off my child _____ from Support By Design.

Name	Relationship	Contact Info

Parent's Signature: _____ Date: _____

Developmental History

PRENTAL HISTORY

Previous pregnancies (number and problems):

History of pregnancy with this child (use of medication, health of mother, complication or problems):

Length of pregnancy (number of weeks, length of labor):

History of pregnancy (type of delivery, complication):

EARLY HISTORY

Condition of newborn (Apgar scores, ht/wt, problems):

Feeding (method, duration, weaning, eating patterns, problems):

Sleep (patterns, problems):

Activity level (child's favorite pastimes, reaction to movement):

Toilet training (age, method, duration, problems):

Medical history (hospitalization, allergies, ear infections, other problems):

Developmental milestones

Age at which child completed the following:

Sat alone _____crawled _____walked _____ran_____

Used words _____ 2- Word sentence _____

3-to-4-word sentence_____ asked questions_____

Drank from a cup_____ dressed self _____used spoon/fork_____

Describe general coordination: _____

Describe ability to communicate: _____

Any unusual behaviors or problems (head banging, temper tantrums, rocking, breath holding, etc):

PRESENT STATUS

Current medication:

Frequency and types of illnesses:

Sleep: Toileting:

Eating: Activity level:

Interaction with other children:

Attendance at preschool or day care: behavior, preacademic performance, socialization, plays patterns

Describe coordination:

Describe language;

Note any problems:

Name/address of physician:

Name/ address of other specialists treating child:

History of family since birth of child: (moves, changes, significant traumas, problems Note if any siblings are having or have had problems)

Food Allergy Action Plan

Students
Name: _____ D.O.B: _____ Therapist: _____

ALLERGY TO: _____

Asthmatic Yes*☐ No☐ *Higher risk for severe reaction

● STEP 1: TREATMENT ●

Symptoms:	**Give Checked Medication****: **(to be determined by physician authorizing treatment)	
○ If a food allergen has been ingested, but no symptoms	☐ Epinephrine	☐ Antihistamine
○ Mouth Itching , tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
○ Skin Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
○ Gut Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
○ Throat↑ Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
○ Lung↑ Shortness of breath, repetitive coughing , wheezing	☐ Epinephrine	☐ Antihistamine
○ Heart↑ Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
○ Other↑	☐ Epinephrine	☐ Antihistamine
○ If reaction is progression (several of the above areas affected), give:	☐ Epinephrine	☐ Antihistamine

Potentially life-threatening, the severity of symptoms can quickly change.

DOSAGE
Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen®Jr. Twinject® 0.3mg Twinject® 0.15 mg (see reverse side for instructions)

Antihistamines: give _____
Medication/dose/route

Other: give _____
Medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

● STEP 2: EMERGENCY CALLS ●

1. Call 911 (or Rescue Squad: _____) State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Dr. _____ Phone Number:_____
3. Parent _____ Phone number (s) _____
4. Emergency contacts Name/ Relationship Phone Number(s)
a. _____ 1._____ 2. _____
b. _____ 1._____ 2. _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY:

Parent/ Guardian's signature _____ Date _____
Doctor's Signature _____ Date _____

Consent for Emergency Treatment

Support by Design staff will perform with your consent the Emergency Procedures as needed for your child as follows:

1. Call 911
2. Perform first aid as needed
3. Perform CPR as needed
4. Perform choking procedures as needed
5. Perform treatment as directed by your Physician for an Allergic reaction

I _____ give my consent for SBD staff to perform the above emergency treatment for my child _____ _____

Signature _____

Date _____

Parental Consent to Use E-mail to Exchange Personally Identifiable Information

Parent's Name:_____
E-mail Address: _____
Child's Name: _____ D.O.B _____

At your request, you have chosen to communicate personally identifiable information concerning your child's treatment by e-mail without the use of encryption. Sending personally identifiable information by e-mail has a number of risks that you should be aware of prior to giving your permission. These risks include, but are not limited to, the following:

- E-mail can be forwarded and stored in electronic and paper format easily without prior to knowledge of the parent.
- E-mail senders can misaddress an e-mail and personally identifiable information can be sent to incorrect recipients by mistake.
- E-mail sent over the Internet without encryption is not secure and can be intercepted by unknown third parties.
- E-mail content can be changed without the knowledge of the sender or receiver.
- Backup copies of e-mail may still exist even after the sender and receiver have deleted the messages.
- Employers and online service providers have a right to check e-mail sent through their systems.
- E-mail can contain harmful viruses and other programs.

Parental Acknowledgment and Agreement

I acknowledge that I have read and understand the items above which describe inherent risks of using e-mail to communicate personally identifiable information. Nevertheless, I authorize Support by Design staff and therapists to communicate with me at my e-mail address concerning my child's treatment at Support by Design, including but not limited to communication regarding service delivery, his/her progress and any other related matters. I understand that use of e-mail without encryption presents the risks noted above and may result in unintended disclosure of such information.

(Optional) In addition, I give permission for members of my child's treatment team to communicate personally identifiable information concerning my child with each other using unencrypted e-mail. Early intervention team members who I give permission to use unencrypted e-mail to communicate with each other about my child include:

1. _____ with the e-mail address _____
2. _____ with the e-mail address _____
3. _____ with the e-mail address _____
4. _____ with the e-mail address _____
5. _____ with the e-mail address _____

Parent's Signature _____ Date _____