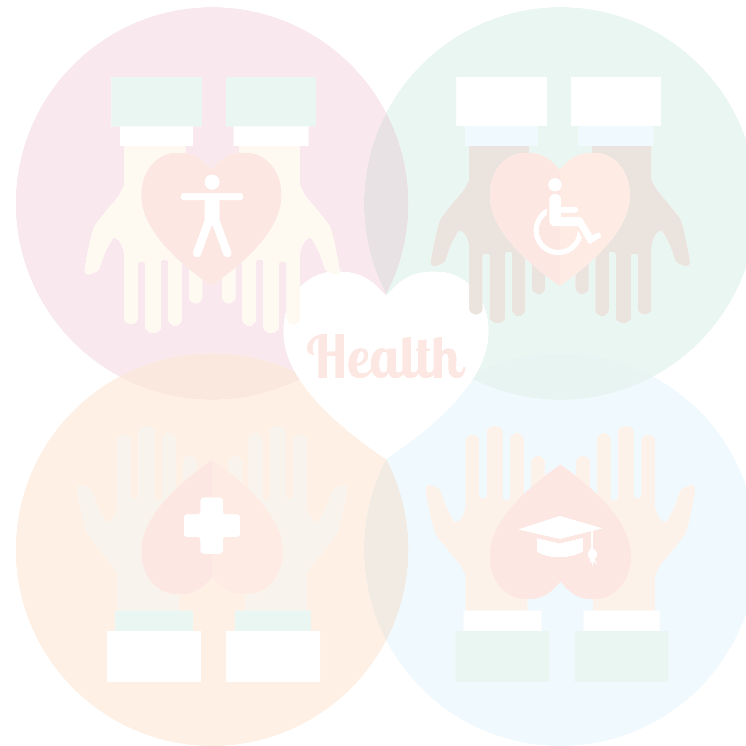
MY SHARED PLAN OF CARE



MY NAME: ______________________________

CONFIDENTIAL

My Shared Plan of Care was Changed On:							
Date	Who changed it?	What changed?	Page #	Date	Who changed it?	What changed?	Page #

My name (child's name): ____________________________________

Date of Birth: ____

CONFIDENTIAL

My Shared Plan of Care was Changed On:

Date	Who changed it?	What changed?	Page #	Date	Who changed it?	What changed?	Page #

My name (child's name): ______________________________

Date of Birth: ______________________________

CONFIDENTIAL

My Shared Plan of Care was Changed On:

Date	Who changed it?	What changed?	Page #	Date	Who changed it?	What changed?	Page #

My name (child's name): ___________________________________

Date of Birth: ___________________________________

MY SHARED PLAN OF CARE

What is "My Shared Plan of Care"?

"My Shared Plan of Care" is a self-management tool that can help you keep track of what is going on with your health. Take this information with you when you visit your providers. It may help you be an active partner in your care. ***Keep your plan in a safe place. It has confidential information.***

What is "Self-Management"?

Self-management means that you play a key role in managing your care. You are part of a team, along with your Special Child Health Services case manager, care coordinator, doctors, nurses, pharmacists and others, working together to manage your health.

How can I make the most of "My Shared Plan of Care"?

1. ***Fill in the parts you know*** in "My Shared Plan of Care".

2. If there are ***things you don't know, work with your care team members*** (e.g., case manager, care coordinator, doctors, nurses, therapists, pharmacists, etc.) ***to complete "My Shared Plan of Care"***. ***If there are parts that do not apply to you, then you do not need to fill them in.***

3. ***Take "My Shared Plan of Care" with you to all of your health care appointments.***

4. ***With your consent***, your ***care team can review "My Shared Plan of Care"*** for a current picture of your health and to help you ***keep the information accurate, up-to-date, and complete***. You can also work together to define problems, set priorities and goals, create treatment plans, and solve problems.

My Special Child Health Services Case Manager is: ______________________________

County: ______________________________

CONFIDENTIAL

<table>
<tr><td colspan="2">My name (child's name):</td><td colspan="2">Date of Birth:</td><td>Gender:</td></tr>
<tr><td colspan="4">This form was completed by:</td><td>Relationship:</td></tr>
<tr><td colspan="5">Parent/Guardian's Name:</td></tr>
<tr><td colspan="5" align="center">My Address (child's)</td></tr>
<tr><td colspan="5">Street/Apt # (if needed):</td></tr>
<tr><td colspan="5">City/State/Zip Code:</td></tr>
<tr><td colspan="5">My Phone:</td></tr>
<tr><td colspan="5">My Email:</td></tr>
<tr><td colspan="2" align="center">Parent A/Guardian's Address</td><td colspan="3" align="center">Parent B/Guardian's Address (Complete this section if needed)</td></tr>
<tr><td colspan="2">Street/Apt # (if needed):</td><td colspan="3">Street/Apt # (if needed):</td></tr>
<tr><td colspan="2">City/State/Zip Code:</td><td colspan="3">City/State/Zip Code:</td></tr>
<tr><td colspan="2">Parent/Guardian's Phone:</td><td colspan="3">Parent/Guardian's Phone:</td></tr>
<tr><td colspan="2">Parent/Guardian's Email:</td><td colspan="3">Parent/Guardian's Email:</td></tr>
</table>

My name (child's name): ______________________________

Date of Birth: ______________________________

Please list all people living in your home and other people that support you:		
Name	**Relationship**	**Do they live in your home? Y/N**

My Insurance
Primary Insurance Name:
Secondary Insurance Name:
Dental Insurance Name:
Vision Insurance Name:

My name (child's name): ______________________________

Date of Birth: ______________________________

My Diagnoses		

I want the person working with me to know:

I need help with (check all that apply): ❑ Transportation ❑ Vision ❑ Hearing ❑ Mobility ❑ English as a Second Language
❑ Social ❑ Behavior ❑ Communication ❑ Feeding ❑ Learning ❑ Diet
❑ Other (please specify) ______________________________ **Comments:**

My Religion/Spirituality impacts my health care: ❑ YES ❑ NO
Comments:

I learn best by: ❑ Reading ❑ Being talked to ❑ Being shown how ❑ Seeing pictures or videos
❑ Other (please specify) ______________________________

I have access to the Internet: ❑ YES ❑ NO	I have a Healthcare Proxy: ❑ YES ❑ NO (If YES, attach document)
I have a service animal: ❑ YES ❑ NO	I have a therapy animal: ❑ YES ❑ NO

My name (child's name): ______________________________

Date of Birth: ______________________________

My Emergency Plan		
Emergency Contact Name:	**Phone Number:**	**Relationship:**
Back-up Emergency Contact Name:	**Phone Number:**	**Relationship:**
Call my Emergency Contact if the following symptoms are present:		
Call 9-1-1 if the following symptoms are present, (and call my Emergency Contact, too):		
Take these steps while waiting for my Emergency Contact or medical help to arrive:		
I am registered with NJ Register Ready (www.registerready.nj.gov) ❑ YES ❑ NO		

My name (child's name): ______________________________

Date of Birth: ______________________________

My Food Allergies/Intolerances			
Food	Reaction	Date Occurred	Comments

My Drug Allergies/Intolerances			
Drug Name	Reaction	Date Occurred	Comments
Other Allergies:			

My name (child's name): ______________________________

Date of Birth: ______________________________

My Pharmacy	
Pharmacy Name:	Phone Number:
Pharmacy Name:	Phone Number:

My Prescription Medications

Start Date	Prescribed by	Drug Name	Directions	Why I take this med	Stop Date (If no longer taking med)	Comments

My name (child's name): ______________________

Date of Birth: ______________________

My Prescription Medications (continued...)						
Start Date	Prescribed by	Drug Name	Directions	Why I take this med	Stop Date (If no longer taking med)	Comments

My name (child's name): ______________________________

Date of Birth: ______________________________

My Over-the-Counter Medications			
Name	**Directions**	**Why I take this med**	**Comments**

My name (child's name): ______________________________

Date of Birth: ______________________________

My Over-the-Counter Medications (continued...)			
Name	**Directions**	**Why I take this med**	**Comments**

My name (child's name): ______________________________

Date of Birth: ______________________________

My Primary Care Provider			
Primary Care Provider's Name	**Care Coordinator's Name**	**Office Phone Number**	**Email**
Treatment Plan (Including labs, radiology, and diagnostic testing)			
Hospital Privileges:		**Immunizations Up-to-date:** ❑ YES ❑ NO (Attach immunization record or fill out pages 28&29)	

My name (child's name): ________________________________

Date of Birth: ________________________________

Other Provider (This includes medical, mental health, others)			
Type of Provider	**Provider's Name**	**Office Phone Number**	**Email**
Treatment Plan (Including labs, radiology, and diagnostic testing)			
Hospital Privileges:			

Other Provider (This includes medical, mental health, others)			
Type of Provider	**Provider's Name**	**Office Phone Number**	**Email**
Treatment Plan (Including labs, radiology, and diagnostic testing)			
Hospital Privileges:			

My name (child's name): ______________________________

Date of Birth: ______________________________

Other Provider (This includes medical, mental health, others)			
Type of Provider	Provider's Name	Office Phone Number	Email
Treatment Plan (Including labs, radiology, and diagnostic testing)			
Hospital Privileges:			

Other Provider (This includes medical, mental health, others)			
Type of Provider	Provider's Name	Office Phone Number	Email
Treatment Plan (Including labs, radiology, and diagnostic testing)			
Hospital Privileges:			

My name (child's name): ___________________________________

Date of Birth: ____

Other Provider (This includes medical, mental health, others)			
Type of Provider	Provider's Name	Office Phone Number	Email
Treatment Plan (Including labs, radiology, and diagnostic testing)			
Hospital Privileges:			

Other Provider (This includes medical, mental health, others)			
Type of Provider	Provider's Name	Office Phone Number	Email
Treatment Plan (Including labs, radiology, and diagnostic testing)			
Hospital Privileges:			

*If you need more space, use extra pages.

My name (child's name): ___________________________________

Date of Birth: ____

My Home Care

I have a **private duty** (check all that apply):

❑ **Nurse/Aid** ❑ **Physical Therapist** ❑ **Occupational Therapist** ❑ **Speech Therapist** ❑ **Social Worker** ❑ **Respite Care**

Home Health Care Agency's Name	Case Manager's Name	Office Phone Number

Ordered by	Office Phone Number	Office Fax Number	Email

Treatment Plan

My name (child's name): ____________________________________

Date of Birth: ____

Home Care Infusion

I have **home care infusion** (e.g.,nutrition, IV therapy). If YES, list:

Home Care Infusion Agency's Name	Case Manager's Name	Office Phone Number

Ordered by	Office Phone Number	Office Fax Number	Email

Durable Medical Equipment

I use **durable medical equipment** (e.g., wheelchair, walker, hospital bed). If YES, list:

Durable Medical Equipment Agency's Name	Case Manager's Name	Office Phone Number

Ordered by	Office Phone Number	Office Fax Number	Email

Orthotic and/or a Prosthetic

I use **an orthotic and/or a prosthetic** (e.g., leg brace, prosthetic limb). If YES, list::

Orthotic/Prosthetic Agency's Name	Case Manager's Name	Office Phone Number

Ordered by	Office Phone Number	Office Fax Number	Email

My name (child's name): ______________________________

Date of Birth: ______________________________

My Dentist		
Dentist's Name	**Office Phone Number**	**Email**
Treatment Plan		

My name (child's name): ________________________________

Date of Birth: ________________________________

My Eye Doctor		
Eye Doctor's Name	**Office Phone Number**	**Email**
Treatment Plan		
I wear glasses: ❑ YES ❑ NO	I wear contacts: ❑ YES ❑ NO	

My name (child's name): ______________________________

Date of Birth: ______________________________

My Audiologist		
Audiologist's Name	**Office Phone Number**	**Email**
Treatment Plan		
I wear hearing aids: ❑ YES ❑ NO (If YES, Type of Hearing Aid ____________________, Date Changed _____________)		

My Transportation Information		
I have my own form of transportation: ❑ YES ❑ NO (If NO, complete section below)		
Transportation Agency's Name	**Contact Person's Name**	**Phone Number**

My name (child's name): ________________________________

Date of Birth: ____

My Education			
School Name		School Address	
School District		Classroom Type	
Contact Person's Name	Role (e.g., nurse, teacher, principal)	Phone Number	Email
1.			
2.			
3.			
4.			

I have an **IEP/IFSP**: ❑ **YES** ❑ **NO** (If YES, Date of last IEP/IFSP): Date ____________________ **(Attach IEP/IFSP)**

I have a **504 Plan**: ❑ **YES** ❑ **NO** (If YES, Date of last 504 plan): Date ____________________ **(Attach 504 Plan)**

Attendance: ❑ **GOOD** ❑ **POOR** (If POOR, explain my attendance and how it affects my education):

Behavior: ❑ **GOOD** ❑ **POOR** (If POOR, explain my behavior and how it affects my education):

My name (child's name): ____________________________________

Date of Birth: ____

My Transition to Adulthood

I have started a Transition to Adulthood Plan with members of my care team:

❑ **YES** (If YES, provide details of your plan below; e.g., school, job, relationships, housing) ❑ **NO** ❑ **N/A** (If less than 12 years old)

I have found an adult Primary Care Provider: ❑ **YES** ❑ **NO** ❑ **N/A**

My name (child's name): ________________________________

Date of Birth: ________________________________

My Hospitalizations, Emergency Room Visits, and Other Procedures			
Date(s)	Hospital/Facility Name	Reason for Admission	Treatment/Procedure(s)

My name (child's name): ________________________________

Date of Birth: ________________________________

My Hospitalizations, Emergency Room Visits, and Other Procedures			
Date(s)	Hospital/Facility Name	Reason for Admission	Treatment/Procedure(s)

My name (child's name): ___________________________

*If you need more space, use extra pages.

Date of Birth: ___________________________

My Follow-Up Appointments				
Date	Things to Remember for My Appointment	Provider Name	Type of Provider	Treatment Provided

My name (child's name): ______________________________

Date of Birth: ______________________________

My Follow-Up Appointments				
Date	Things to Remember for My Appointment	Provider Name	Type of Provider	Treatment Provided

*If you need more space, use extra pages.

My name (child's name): ____________________________________

Date of Birth: ____

My Additional Information

This section is to be completed by you in partnership with your care team members. This information may include concerns about your medical condition(s), barriers, or goals. This information should also include observations, actions, and solutions.

Date	Information:

My name (child's name): ________________________________

Date of Birth: ________________________________

My Additional Information

This section is to be completed by you in partnership with your care team members. This information may include concerns about your medical condition(s), barriers, or goals. This information should also include observations, actions, and solutions.

Date	Information:

*If you need more space, use extra pages.

My name (child's name): ____________________

Date of Birth: ____________________

I have actively participated in the development of My Shared Plan of Care. I understand and agree with the information in this plan.
I know that I can work with my providers at any time to make changes to my Shared Plan of Care.

Name (Printed)	Signature	Date
Parent/Guardian Name (Printed)	**Signature**	**Date**
Primary Care Provider's Name (Printed)	**Signature**	**Date**
Care Coordinator's Name (Printed)	**Signature**	**Date**

Informed Consent

I authorize that my care team members listed in my Shared Plan of Care have access to my entire Shared Plan of Care ❑ **YES** ❑ **NO**

Name (Printed)	Signature	Date
Parent/Guardian Name (Printed)	**Signature**	**Date**

I (or my authorized legal guardian) am providing consent for the following additional people to have full access to my Shared Plan of Care

Name of Person/Relationship	Signature	Date

My name (child's name): ____________________________________

Date of Birth: ____________________________________

Vaccine Administration Record for Children and Teens

Patient name ______________________

Birthdate ______________ Chart number ______________

PRACTICE NAME AND ADDRESS

Before administering any vaccines, give copies of all pertinent Vaccine Information Statements (VISs) to the child's parent or legal representative and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Vaccine	Type of Vaccine[1]	Date vaccine given (mo/day/yr)	Funding Source (F,S,P)[2]	Site[3]	Vaccine		Vaccine Information Statement (VIS)		Vaccinator[5] (signature or initials and title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Hepatitis B[6] (e.g., HepB, Hib-HepB, DTaP-HepB-IPV) Give IM.[7]									
Diphtheria, Tetanus, Pertussis[6] (e.g., DTaP, DTaP/Hib, DTaP-HepB-IPV, DT, DTaP-IPV/Hib, DTaP-IPV, Tdap, Td) Give IM.[7]									
***Haemophilus influenzae* type b**[6] (e.g., Hib, Hib-HepB, DTaP-IPV/Hib, DTaP/Hib, Hib-MenCY) Give IM.[7]									
Polio[6] (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV) Give IPV Subcut or IM.[7] Give all others IM.[7]									
Pneumococcal (e.g., PCV7, PCV13, conjugate; PPSV23, polysaccharide) Give PCV IM.[7] Give PPSV Subcut or IM.[7]									
Rotavirus (RV1, RV5) Give orally (po).									

▶ **See page 2** to record measles-mumps-rubella, varicella, hepatitis A, meningococcal, HPV, influenza, and other vaccines (e.g., travel vaccines).

How to Complete this Record

1. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the site where vaccine was administered as either RA (right arm), LA (left arm), RT (right thigh), LT (left thigh), or NAS (intranasal).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.
6. For combination vaccines, fill in a row for each antigen in the combination.
7. IM is the abbreviation for intramuscular; Subcut is the abbreviation for subcutaneous.

Abbreviation	Trade Name and Manufacturer
DTaP	Daptacel (Sanofi Pasteur); Infanrix (GlaxoSmithKline [GSK]); Tripedia (Sanofi Pasteur)
DT (pediatric)	Generic (Sanofi Pasteur)
DTaP-HepB-IPV	Pediarix (GSK)
DTaP-IPV/Hib	Pentacel (Sanofi Pasteur)
DTaP-IPV	Kinrix (GSK); Quadracel (Sanofi Pasteur)
HepB	Engerix-B (GSK); Recombivax HB (Merck)
HepA-HepB	Twinrix (GSK); can be given to teens age 18 and older
Hib	ActHIB (Sanofi Pasteur); Hiberix (GSK); PedvaxHIB (Merck)
Hib-MenCY	MenHibrix (GSK)
IPV	Ipol (Sanofi Pasteur)
PCV13	Prevnar 13 (Pfizer)
PPSV23	Pneumovax 23 (Merck)
RV1	Rotarix (GSK)
RV5	RotaTeq (Merck)
Tdap	Adacel (Sanofi Pasteur); Boostrix (GSK)
Td	Decavac, Tenivac (Sanofi Pasteur); Generic (MA Biological Labs)

Technical content reviewed by the Centers for Disease Control and Prevention

Vaccine Administration Record for Children and Teens (continued)

Patient name ____________________

Birthdate ____________________ Chart number ____________________

PRACTICE NAME AND ADDRESS

Before administering any vaccines, give copies of all pertinent Vaccine Information Statements (VISs) to the child's parent or legal representative and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Vaccine	Type of Vaccine[1]	Date vaccine given (mo/day/yr)	Funding Source (F,S,P)[2]	Site[3]	Vaccine		Vaccine Information Statement (VIS)		Vaccinator[5] (signature or initials and title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Measles, Mumps, Rubella[6] (e.g., MMR, MMRV) Give Subcut.[7]									
Varicella[6] (e.g., VAR, MMRV) Give Subcut.[7]									
Hepatitis A (HepA) Give IM.[7]									
Meningococcal ACWY; CY (e.g., MenACWY [MCV4]; Hib-MenCY) Give MenACWY and Hib-MenCY IM.[7]									
Meningococcal B (e.g., MenB) Give MenB IM.[7]									
Human papillomavirus (e.g., HPV2, HPV4, HPV9) Give IM.[7]									
Influenza (e.g., IIV3, IIV4, ccIIV3, RIV3, LAIV4) Give IIV3, IIV4, ccIIV3, and RIV3 IM.[7] Give LAIV4 NAS.[7]									
Other									

▶ **See page 1** to record hepatitis B, diphtheria, tetanus, pertussis, *Haemophilus influenzae* type b, polio, pneumococcal, and rotavirus vaccines.

How to Complete this Record

1. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the site where vaccine was administered as either RA (right arm), LA (left arm), RT (right thigh), LT (left thigh), or NAS (intranasal).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.
6. For combination vaccines, fill in a row for each antigen in the combination.
7. IM is the abbreviation for intramuscular; Subcut is the abbreviation for subcutaneous.

Abbreviation	Trade Name and Manufacturer
MMR	MMRII (Merck)
VAR	Varivax (Merck)
MMRV	ProQuad (Merck)
HepA	Havrix (GlaxoSmithKline [GSK]); Vaqta (Merck)
HepA-HepB	Twinrix (GSK)
HPV2	Cervarix (GSK)
HPV4, HPV9	Gardasil, Gardasil 9 (Merck)
LAIV4 (live attenuated influenza vaccine, quadrivalent)	FluMist (MedImmune)
IIV3 (inactivated influenza vaccine, trivalent), IIV4 (inactivated influenza vaccine, quadrivalent), ccIIV3 (cell culture-based inactivated influenza vaccine, trivalent), RIV3 (inactivated recombinant influenza vaccine, trivalent)	Fluarix (GSK); Flublok (Protein Sciences Corp.); Afluria, Fluad, Flucelvax, Fluvirin (Seqirus); FluLaval (GSK); Fluzone (Sanofi Pasteur)
MenACWY	Menactra (Sanofi Pasteur); Menveo (GSK)
HibMenCY	MenHibrix (GSK)
MenB	Bexsero (GSK); Trumenba (Pfizer)