



Care Notebook

Training with One Page Profile

oklahomafamilynetwork.org

What is a Care Notebook?

An organizing tool for families who have children with special health care needs. It is used to keep track of important health care and school information. A Care Notebook makes it easier to find and share key information with others who are part of a person's care team. This is most important in emergent, transitional or new situations.



Care Notebook



An organizational tool for maintaining personal and medical information.



OFN Care Notebook Tabs:

- Cover sheet
- Medical Information
- Dental Health
- Providers
- Resources
- Evaluations
- IEP/IFSP/IP
- Insurance/Legal Information



Types of Documents

- Allergy Log
- Appointment Log *
- Behavior Event Log *
- Blood Pressure Tracking
- Blood Sugar Tracker
- Calendar *
- Care Schedule*
- Childcare Respite and Babysitter Contacts
- Child's Development History *
- Communication Log
- Cover Page (photo when well)*
- Daily Medication Tracking*
- Dental Care



Types of Documents

- Diet Tracking
- Early Intervention
- Emergency Plan
- Equipment and Supplies
- Evaluations *
- Getting to Know Me *
- Growth Tracker *
- Healthcare Providers *
- Home Visitor Log*
- Hospitalizations
- How My Day Went
- In Case of Emergency



PORTABLE MEDICAL SUMMARY: NAME: _____

NAME:	BIRTH DATE:
ADDRESS:	PARENT/GUARDIAN:
	HOME/WORK PHONE:
PRIMARY LANGUAGE:	EMERGENCY CONTACT:
	PHONE NUMBER (S):
PERTINENT PERSONAL CHARACTERISTICS:	

MEDICATIONS		Allergies:	REACTIONS:
DAILY Rx:	MONTHLY Rx:		
Rx PRN:		HERBS/SUPPLEMENTS:	
OXYGEN: YES <input type="checkbox"/> NO <input type="checkbox"/> QUANTITY: _____			
IMMUNIZATIONS UP TO DATE: YES <input type="checkbox"/> NO <input type="checkbox"/>		IMMUNIZATION RECORD (PLEASE ATTACH)	

PRIMARY DIAGNOSIS:	AGE AT TIME OF DIAGNOSIS:
OTHER DIAGNOSIS:	

Hospitalizations/Surgeries/Procedures	Date:	Hospital Name:	Physician:

BASELINE VITALS:	BASELINE NEUROLOGICAL STATUS:
RESPIRATIONS _____ TEMP _____ O2 _____ PULSE _____ BP _____ / _____	
BASELINE FINDINGS:	

COMMON PRESENTING PROBLEMS:	TREATMENT CONSIDERATIONS:
1. _____	1. _____
2. _____	2. _____

PORTABLE MEDICAL SUMMARY: NAME: _____

PRIMARY CARE PHYSICIAN:	EMERGENCY PHONE:
	FAX:
OTHER PHYSICIAN:	OTHER PHYSICIAN:
EMERGENCY PHONE:	EMERGENCY PHONE:
FAX:	FAX:
OTHER PHYSICIAN:	OTHER PHYSICIAN:
EMERGENCY PHONE:	EMERGENCY PHONE:
FAX:	FAX:

MEDICAL EQUIPMENT:	MEDICAL SUPPLIES:	PROVIDER:	CONTACT INFO:

NUTRITION/FITNESS GOALS:	PROVIDER:	CONTACT INFO:

FUNCTIONAL CAPABILITIES:	BRIEF SUMMARY	FUTURE PLANS: AGENCIES INVOLVED/REFERRALS MADE

SERVICES CURRENTLY RECEIVING:	PROVIDER CONTACT INFO:

HEALTH INSURANCE PRIMARY:	HEALTH INSURANCE SECONDARY:
NAME:	NAME:
PHONE:	PHONE:

OTHER COMMENTS:

Signature Parent/Guardian: _____ Date: _____
 Signature Primary Care Provider _____ Phone: _____



Child's Development History

It is Important to keep a record of many of your child's 'firsts.' This may help your doctor determine a diagnosis for your child and have a better idea of their developmental history.

Name:		
Skill:	Age:	Notes:
Smiled:		
Held Up Head:		
Rolled Over:		
Sat Up:		
Got First Tooth:		
Started Solid Food:		
Crawled:		
Spoke First Word:		



Daily Medication Tracking

Name

Medication							
Date							
Dosage							
How Often							
Note							
Time 12:00 AM							
1:00 AM							
2:00 AM							
3:00 AM							
4:00 AM							
5:00 AM							
6:00 AM							
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							



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)	



Home Visitor Log

Use this log to help keep track of providers who come to your home on behalf of your child.

Date	Name	Agency ✓



Healthcare Providers

List contact information for different providers being used, including doctors, specialists, dentist, dietitians, etc.

Care Provider	
Name	
Phone	
Fax	
Start date	
End date	
Address	
E-mail	
Website	
Care Provider	
Name	
Phone	
Fax	
Start date	
End date	
Address	
Email	
Website	
Care Provider	
Name	
Phone	
Fax	

How My Day Went

My Mood Today Was						
Happy	Loud	Rowdy	Energetic	<u>"Stemy"</u>	Giggly	Funny
Sad	Weepy	Defiant	Calm	Sleepy	Spacey	Anxious
Scared	Nervous	Other				
My Activities						
Today I went to						
How I did						
Today I Ate						
Breakfast						
	All	Most	Some	None		
Lunch						
	All	Most	Some	None		
Dinner						
	All	Most	Some	None		
I had a snack at						
I drank						
Toilet						
Diapers	Urine How Many?		Bowel Movement How Many?		Hard	Soft
Toilet	Urine How Many?		Bowel Movement How Many?		Hard	Soft
Accidents						
Medication and Supplements						
I took my Medication						
	Very Well		Not at All		Some, but probably didn't get the full dose	
I Still Need to Take						
Notes About My Day						

Tips to Care for Me

My Morning Routine
Meal times
Breakfast
Lunch
Dinner
Snacks
Other Tips
Homework/School Routines
Bathroom/Bath Time Routines
Bedtime Routine
Medication/Supplements
When I Am Upset, You Can Help Me by

Resources:

Any information that serves as a resource for your child!

- Mobile Crisis Hotline 833-885-2273
- SOC Provider
- Case Manager Contact Information
- DRS Contact Information
- OK Parents Center contact information
- OFN contact information
- Child Care Provider, Catholic Charities, etc.



Evaluations:



- Include Evaluation sheet (copies of all evaluations or tests)
- This may be from SoonerStart (Early Intervention), school, a psychologist, a therapist (OT, PT, Speech), a behavioral therapist, etc.

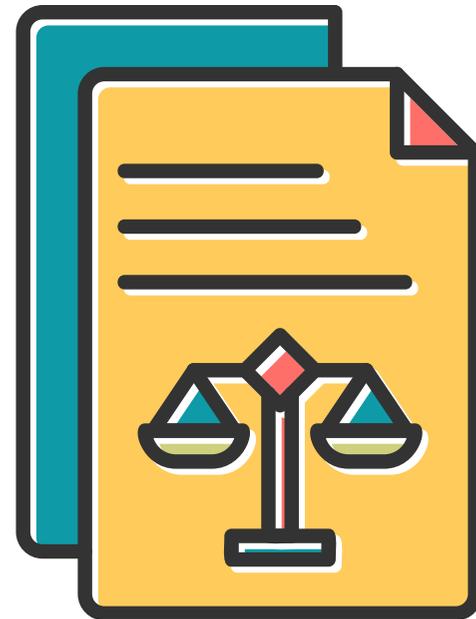
IEP/IFSP/IP:

- Include copies of the most recent and relevant IEP, IFSP, 504 and/or IP



Insurance/Legal Documents:

- Insurance information sheet (copies of cards)
- Guardianship papers
- Living will papers
- Powers of Attorney
- Court Papers
- Etc...



Other documents:

- Journaling sheet
- How my day went
- Instructions for keeping me
- Notes

What is a One Page Profile

It is a person centered, one page document that is easy to use and communicates important information about a person. It includes what is important to them, what people like and admire about them and how they want to be supported. It is written by the person or if they need support, by people who know them well and know how they wish to be supported best.



One Page profiles must include 3 parts:



1

What People Like and Admire

2

Important TO and FOR the person

3

How to support the person

But the options of what you can add are endless!

Taygen Rae Kinder

Allergies!

- Blue dye (#1, #2 & Brilliant Blue)
- Pineapples
- Avocado
- Banana
- Pecans & Walnuts!

ONE THING I AM VERY GREATFULL FOR IS THAT I AM INVOLVED WITH ANYTHING I DO. FOR EXAMPLE MY MOM INVOLVES ME IN ALL MY IEP MEETINGS AND I CAN CHOOSE IF I WANT TO TAKE MY MEDS AND I AM GREATFULL I HAVE A SAY IN WHAT I DO!!

Strengths	Struggles	Things I don't like	Things I love!	Important information!
<ul style="list-style-type: none"> • Strong • Polite • People Pleaser • Hard Worker • Works well with Others • Fast Learner 	<ul style="list-style-type: none"> • Math • Organization • Forgetful • Communicating my feelings when angry or upset • Sticking up for myself 	<ul style="list-style-type: none"> • Confrontation • Loud noises • Yelling • Feeling singled out • Bullies-to me or Others! 	<ul style="list-style-type: none"> • Cows • Horses • Dogs/Puppies • Helping People • Kids/Babies • sports • Giving to others 	<ul style="list-style-type: none"> • Asthma • Overly Anxious in scary situations!

This is an example of a One Page Profile. This page shares what is important TO and FOR Taygen.

It highlights her

- Strengths
- Struggles
- Dislikes
- Things she loves
- Important Information

At a quick glance you see what interest Terrance and learn fun facts about him.

Even with all the color and design this page quickly spells out what is needed to help him succeed and should he become triggered, it clearly shows what he has stated helps him.

MY NAME IS
TERRENCE KALEI
ROBERT
TOYAMA-MANCAO JR.

I LIKE TO BE CALLED TERRENCE OR T, BUT MY FAMILY CALLS ME T.J. B.A.C.A. ROAD NAME: GOKU

NEED TO KNOW

I love video games, Pokeman, Dragon Ball Z, Art and building things!

I want to be in the Military so I can protect my country

It is important for me to have breaks, and to stem when needed. I also get frustrated from difficult tasks because I want to do well.

What people love about me!	My Strengths	My Triggers
FRIENDLY & LOVING	MATH	YELLING
SWEET	SCIENCE	BRIGHT LIGHTS
LOVES TO HELP	EAGER TO LEARN	LOUD NOISES
GREAT WITH SMALL KIDS	STRIVES TO DO WELL	NO OPTIONS

When I get triggered the best way to help me is to give me space, and use calm voices.

TERRI KINDER
REGIONAL COORDINATOR

ABOUT ME
I have been with Oklahoma Family Network (OFN), as the Western Regional Coordinator since 2015. I help to navigate resources and provide support, training & advocacy opportunities to families who have a child, or children, with any kind of disability, medical condition, & mental or behavioral health diagnosis.

FAMILY
Spouse- Jon
Trevin - 22
Teryn-19
Taygen-15

CONTACT
• TERRI-KINDER@OKLAHOMAFAMILYNETWORK.ORG
• 580-467-2279

MY EXPERTISE
ADVOCACY
NAVIGATING RESOURCES
FAMILY SUPPORT

Meet the Teacher

About Me:
Hello there! My name is Lela Smith. I have been a teacher for 12 years and I have been working as a 4th grade teacher for 7 years. I love history and I am very happy to help students understand this lesson.

Fun Facts:

- my favorite color is blue
- I love to read, especially novels.
- I love traveling, nature and the sea.
- I have a dog named Denna
- I love handball

Contact:
• lela@mrsgreen.com
• 555 55 55

Estelle Darcy

Born: November 3rd, 2020
Weight: 8 ounces
Favourite food: Mushed peas

Favourite Colour: Green
Favourite Toy: Pimkie the pig
Favourite Movie: Encanto

ALL ABOUT ME

You can be as creative or simple as you wish to be as long as the information is there that will be needed to support the person the best.

ONE PAGER



NAME: _____ DATE: _____

WHAT PEOPLE LIKE AND ADMIRE ABOUT ME:

WHAT'S IMPORTANT TO ME:

HOW TO BEST SUPPORT ME:



Oklahoma Family Network Training Evaluation

Scan Me



<https://forms.gle/2L2kk74rzwug2vsw6>



We value your input please scan the QR Code or go online to complete the short evaluation.

If you would like to receive electronic copies of the OFN Care Notebook Pages, one-to-one assistance developing a notebook, or more information about OFN please visit:

oklahomafamilynetwork.org

or call

877-871-5072

or 405-271-5072

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Understanding Your Care Notebook...

What is a Care Notebook?

A Care notebook is an organizational tool for maintaining personal and medical information in one central location. This Care Notebook has been designed with collaboration by OFN for families of children and youth with special health care needs and disabilities; as well as mental and behavioral health concerns.

How can a Care Notebook help me?

In caring for your child/youth, you may get information and paperwork from many sources. A Care Notebook helps you organize the most important information in a central place and makes it easier for you to find and share key information with others who are part of your child or youth's care team.

About your Care Notebook

Create it with your child in mind. This binder contains only a basic selection of our Care Notebook documents that you might need to customize your notebook. You can download additional documents from our website. See the Table of Contents for a complete listing of all our documents.

Please contact us if you have any questions. We're happy to assist you.

Scan to Learn More



oklahomafamilynetwork.org

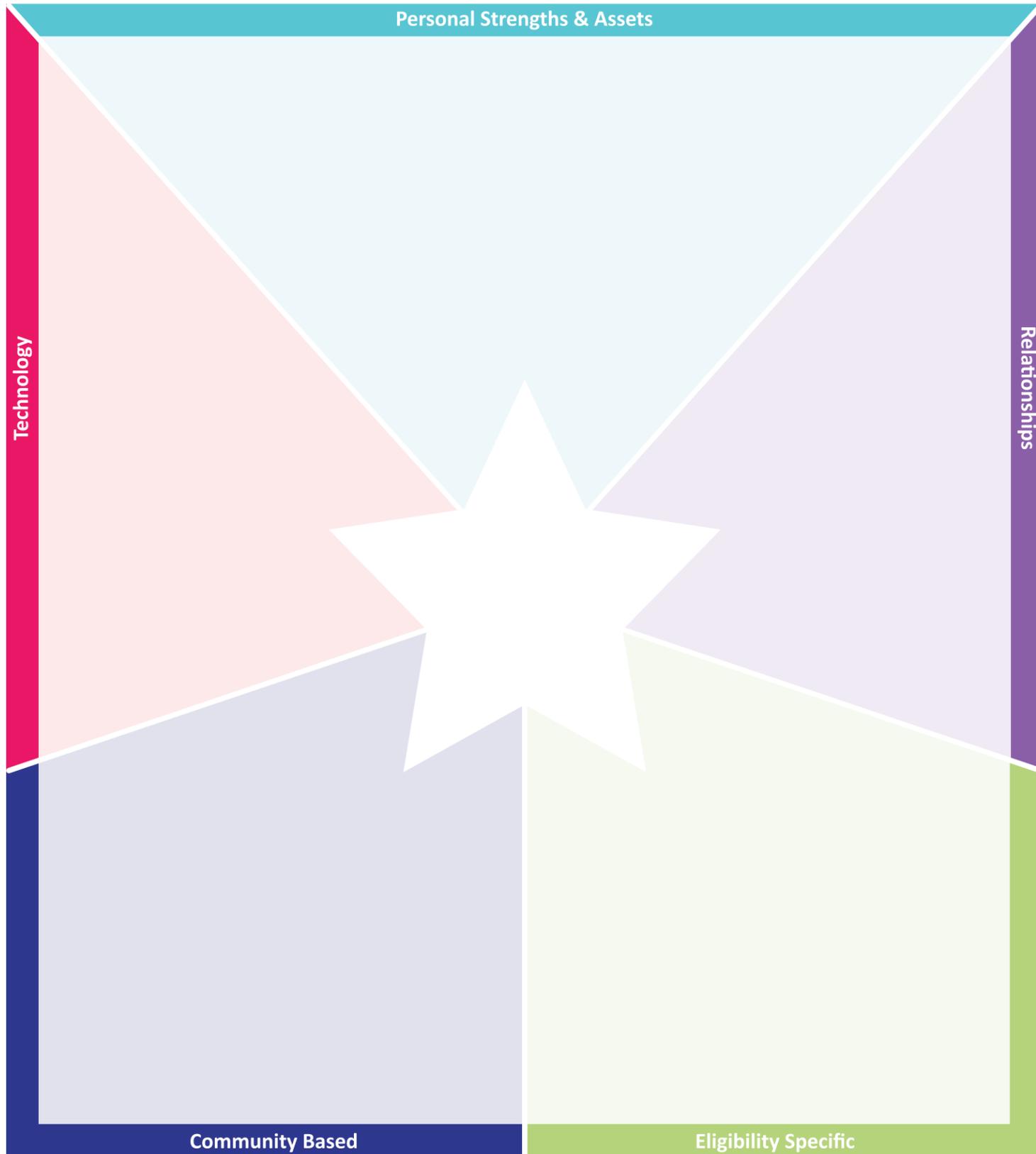


405.271.5072 or 877.871.5072



information@oklahomafamilynetwork.org





NAME: _____ DATE: _____

WHAT PEOPLE LIKE AND ADMIRE ABOUT ME:

Empty rounded rectangular box for writing responses to "WHAT PEOPLE LIKE AND ADMIRE ABOUT ME:"

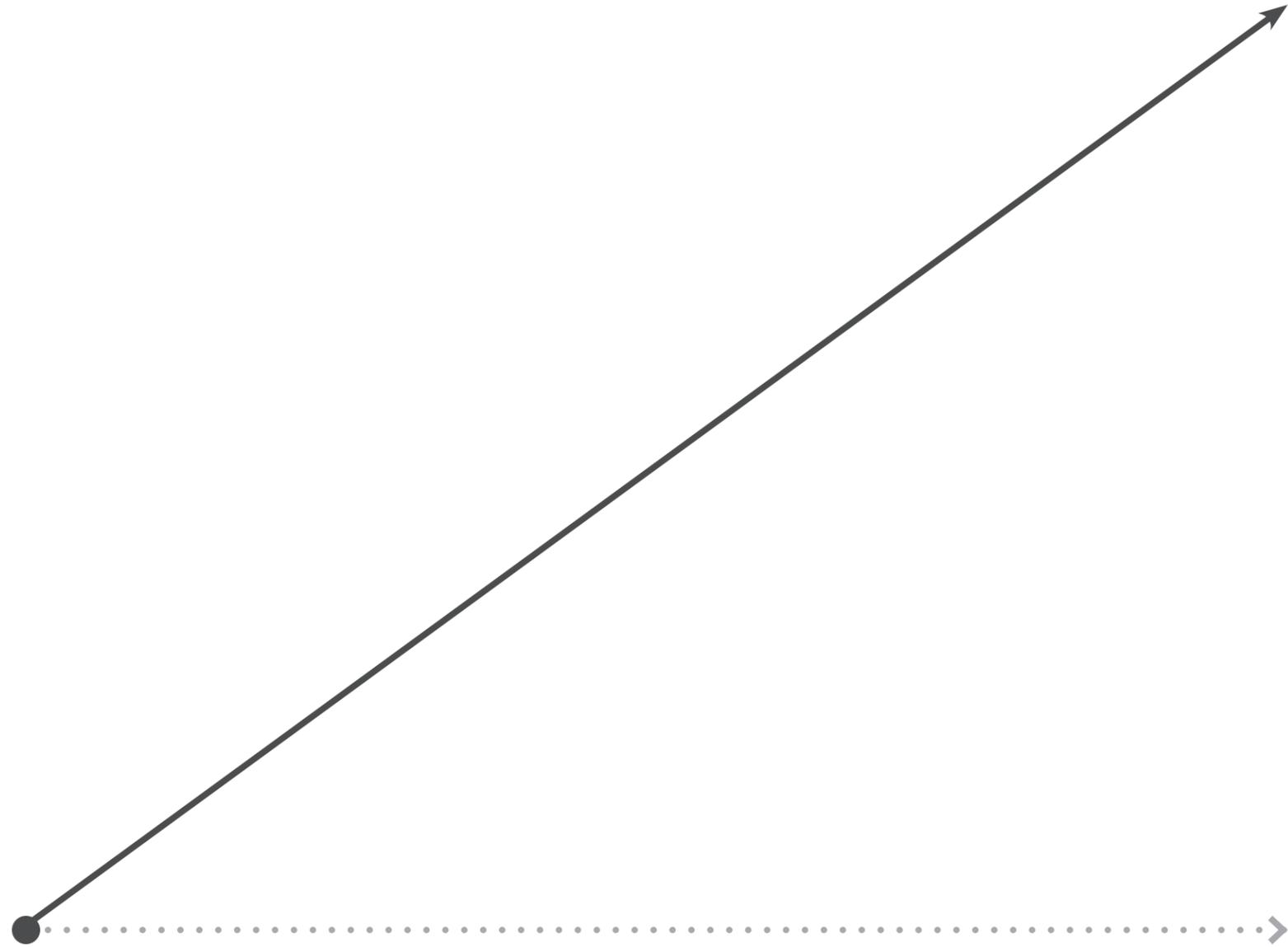
WHAT'S IMPORTANT TO ME:

Empty rounded rectangular box for writing responses to "WHAT'S IMPORTANT TO ME:"

HOW TO BEST SUPPORT ME:

Empty rounded rectangular box for writing responses to "HOW TO BEST SUPPORT ME:"





Vision for What I Want

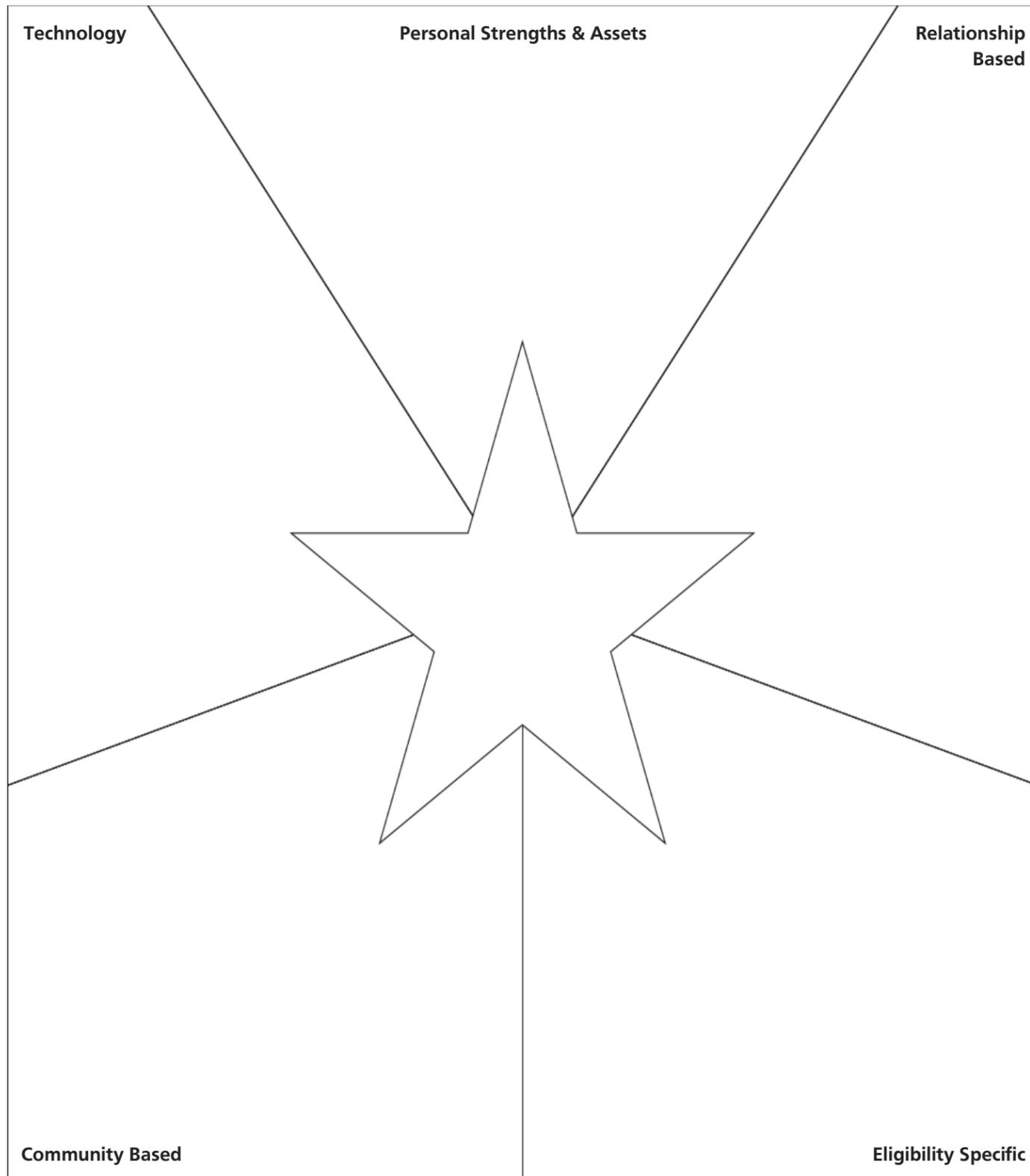
What I Don't Want





Integrated Services and Supports

People need supports to lead good lives. Using a combination of lots of different kinds of support helps to plot a trajectory toward an inclusive, quality, community life. This tool will help families and individuals think about how to work in partnership to support their vision for a good life.



Access the LifeCourse framework and tools at lifecoursetools.com



My LifeCourse Portfolio

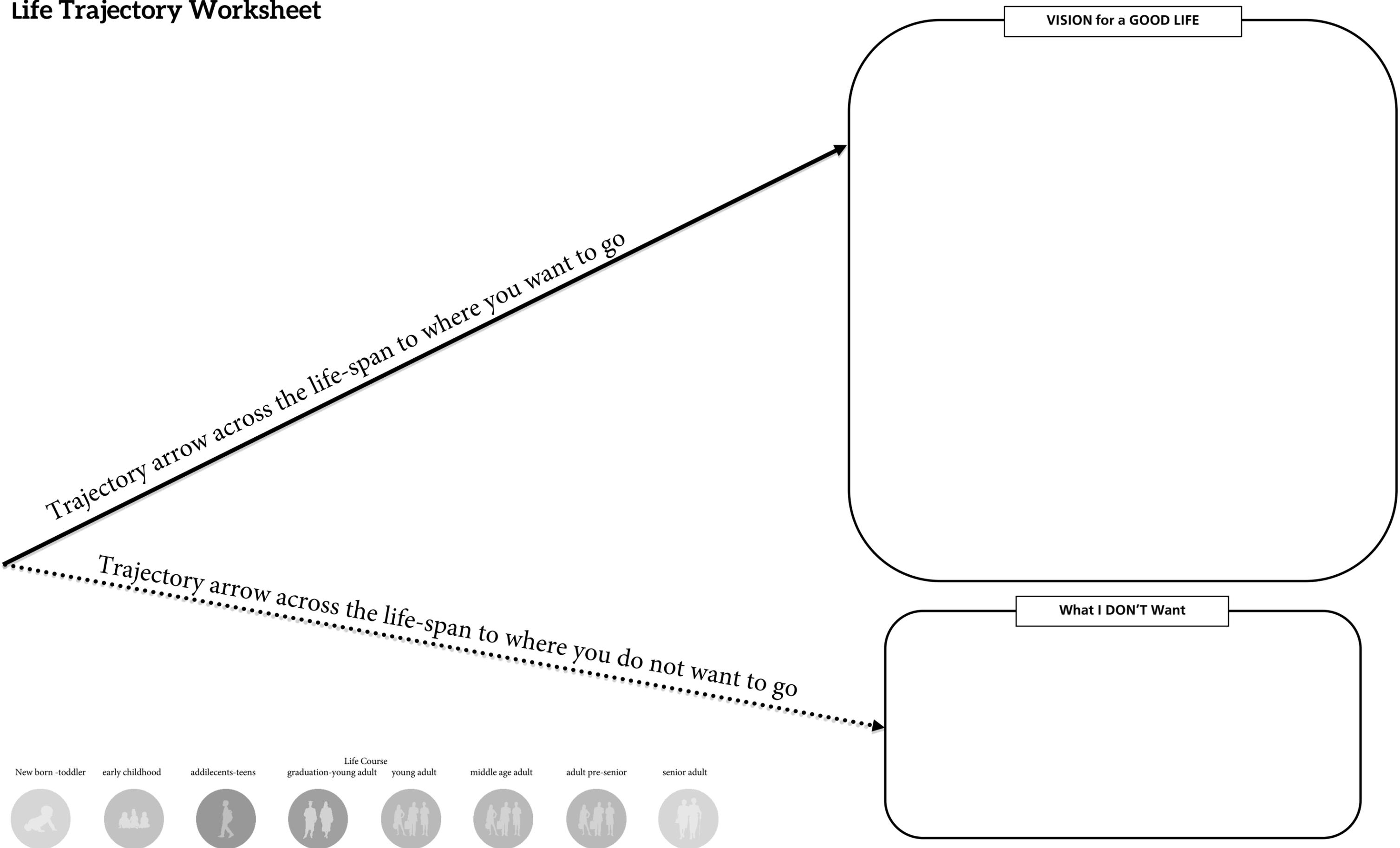
_____ 's **ONE-PAGE PROFILE**

What people like & admire about me

What's Important to ME

How to Best Support ME

Life Trajectory Worksheet



VISION for a GOOD LIFE

What I DON'T Want

Trajectory arrow across the life-span to where you want to go

Trajectory arrow across the life-span to where you do not want to go

- Life Course
- New born -toddler
 - early childhood
 - adilecents-teens
 - graduation-young adult
 - young adult
 - middle age adult
 - adult pre-senior
 - senior adult

Care Notebook Documents

Allergy Log
Appointment Log *
Behavior Event Log *
Blood Pressure Tracking
Blood Sugar Tracker
Calendar *
Care Schedule
Childcare Respite and Babysitter Contacts
Child's Development History *
Communication Log
Daily Medication Tracking*
Dental Care
Diet Tracking
Early Intervention
Emergency Plan
Equipment and Supplies
Evaluations *
Getting to Know Me *
Growth Tracker *
Healthcare Providers *
Home Visitor Log
Hospital and Clinic Information
Hospitalizations
How My Day Went *
In Case of Emergency
Insurance Information *
Journal *
Lab Work Tests and Procedures *
Medications List
Notes *
Out-of-Pocket Expenses
Pharmacy Information *
Phone Call Log *
Portable Medical Summary (2 Pages) *
School Information *
Seizure Record
Therapists
Tips to Care for Me *
Vaccination Record *

All Care Notebook documents are available on our website www.oklahomafamilynetwork.org

**Indicates documents that are in the Basic Care Notebook*



Child's Development History

It is important to keep a record of many of your child's 'firsts.' This may help your doctor determine a diagnosis for your child and have a better idea of their developmental history.

Name:		
Skill:	Age:	Notes:
Smiled:		
Held Up Head:		
Rolled Over:		
Sat Up:		
Got First Tooth:		
Started Solid Food:		
Crawled:		
Spoke First Word:		
Waved "Bye-Bye":		
Walked:		
Spoke First Sentence:		
Toilet Trained:		
Played with Others		
Shared Toys:		
Other:		



Daily Medication Tracking

Name _____

Medication									
Date									
Dosage									
How Often									
Note									
Time 12:00 AM									
1:00 AM									
2:00 AM									
3:00 AM									
4:00 AM									
5:00 AM									
6:00 AM									
7:00 AM									
8:00 AM									
9:00 AM									
10:00 AM									
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10:00 PM									
11:00 PM									



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)	
Ways That Are Helpful to Me	
Things to Avoid (food, Activities, and procedures)	
My Equipment / Assistive Technology	
Other	



Healthcare Providers

List contact information for different providers being used, including doctors, specialists, dentist, dietitians, etc.

Care Provider	
Name	
Phone	
Fax	
Start date	
End date	
Address	
E-mail	
Website	

Care Provider	
Name	
Phone	
Fax	
Start date	
End date	
Address	
Email	
Website	

Care Provider	
Name	
Phone	
Fax	
Start date	
End date	
Address	
Email	
Website	

Care Provider	
Name	
Phone	
Fax	
Start date	
End date	
Address	
Email	
Website	



How My Day Went

My Mood Today Was

Happy	Loud	Rowdy	Energetic	“Stemy”	Giggly	Funny
Sad	Weepy	Defiant	Calm	Sleepy	Spacey	Anxious
Scared	Nervous	Other _____				

My Activities

Today I went to _____

How I did

Today I Ate

Breakfast

All Most Some None

Lunch

All Most Some None

Dinner

All Most Some None

I had a snack at _____

I drank

Toilet

Diapers	Urine How Many?	Bowel Movement How Many?	Hard	Soft
Toilet	Urine How Many?	Bowel Movement How Many?	Hard	Soft

Accidents

Medication and Supplements

I took my Medication

Very Well Not at All Some, but probably didn't get the full dose

I Still Need to Take

Notes About My Day

Insurance Information

Insurance Name _____
Policy/Identification Number _____ Group Number _____
Contact Person and Title _____
Address _____
Phone _____ Fax _____

Insurance Name _____
Policy/Identification Number _____ Group Number _____
Contact Person and Title _____
Address _____
Phone _____ Fax _____

Insurance Name _____
Policy/Identification Number _____ Group Number _____
Contact Person and Title _____
Address _____
Phone _____ Fax _____

Other Name _____
Contact Person and Title _____
Address _____
Phone _____ Fax _____



Pharmacy Information

Pharmacy	
Hours/Days Open	
Drive thru?	<input type="checkbox"/> - Yes <input type="checkbox"/> - No
Address	
Phone	
Fax	
Email	
Website	

Pharmacy	
Hours/Days Open	
Drive thru?	<input type="checkbox"/> - Yes <input type="checkbox"/> - No
Address	
Phone	
Fax	
Email	
Website	

Pharmacy	
Hours/Days Open	
Drive thru?	<input type="checkbox"/> - Yes <input type="checkbox"/> - No
Address	
Phone	
Fax	
Email	
Website	

Pharmacy	
Hours/Days Open	
Drive thru?	<input type="checkbox"/> - Yes <input type="checkbox"/> - No
Address	
Phone	
Fax	
Email	
Website	



PORTABLE MEDICAL SUMMARY

NAME ___-

NAME	BIRTH DATE
ADDRESS	PARENT/GUARDIAN
	HOME/WORK PHONE
PRIMARY LANGUAGE	EMERGENCY CONTACT
	PHONE NUMBER(S)
PERTINENT PERSONAL CHARACTERISTICS	

MEDITATIONS		Allergies	REACTIONS
DAILY Rx	MONTHLY Rx		
Rx PRN		HERBS/SUPPLEMENTS	
OXYGEN YES ___ NO ___ QUANTITY _____			
IMMUNIZATIONS UP TO DATE YES ___ NO ___		IMMUNIZATION RECORD (PLEASE ATTACH)	

PRIMARY DIAGNOSIS	AGE AT TIME OF DIAGNOSIS
OTHER DIAGNOSIS	

Hospitalizations/Surgeries/Procedures	Date	Hospital Name	Physician

BASELINE VITALS	BASELINE NEUROLOGICAL STATUS
RESPIRATIONS _____ TEMP _____	
O2 _____ PULSE _____ BP ____/____	



BASELINE FINDINGS

COMMON PRESENTING PROBLEMS	TREATMENT CONSIDERATIONS
1.	1.
2.	2.

PRIMARY CARE PHYSICIAN	EMERGENCY PHONE
	FAX
OTHER PHYSICIAN	OTHER PHYSICIAN
EMERGENCY PHONE	EMERGENCY PHONE
FAX	FAX
OTHER PHYSICIAN	OTHER PHYSICIAN
EMERGENCY PHONE	EMERGENCY PHONE
FAX	FAX

MEDICAL EQUIPMENT	MEDICAL SUPPLIES	PROVIDER	CONTACT INFO

SERVICES CURRENTLY RECEIVING	PROVIDER CONTACT INFO

HEALTH INSURANCE PRIMARY	HEALTH INSURANCE SECONDARY
NAME	NAME
PHONE	PHONE

OTHER COMMENTS

Signature Parent/Guardian _____ Date _____

Signature Primary Care Provider _____ Phone _____

School Information

School / Preschool _____

Start Date _____

Address _____

Phone _____ Fax _____

Web Site _____

School Nurse _____

Phone _____ Fax _____

Email _____

Contact Person / Title _____

Phone _____ Fax _____

Email _____

Contact Person / Title _____

Phone _____ Fax _____

Email _____

Contact Person / Title _____

Phone _____ Fax _____

Email _____

Tips to Care for Me

My Morning Routine
Meal times
Breakfast
Lunch
Dinner
Snacks
Other Tips
Homework/School Routines
Bathroom/Bath Time Routines
Bedtime Routine
Medication/Supplements
When I Am Upset, You Can Help Me by

STATE OF OKLAHOMA OFFICIAL VACCINATION RECORD



Immunization Service
Oklahoma State
Department of Health

PARENTS

- **SAVE THIS RECORD!** You will need it to enroll your child in child care and school.
- Keep this record in a **safe place**.
- **ALWAYS** take it to any type of health care visit.
- If you think your child is **“too sick to get a shot”** your child probably needs to see the doctor anyway.
- **YES!** Your baby’s immune system can handle several shots at the same time.

QUESTIONS? 1.800.234.6196

HEALTH CARE PROVIDERS:

Record combination vaccines in the rows for each antigen.

**IF YOU FIND THIS CARD,
PLEASE SEND IT TO:**

Immunization Service
Oklahoma State Dept. of Health
1000 NE 10TH Street
Oklahoma City, OK 73117-1207

Child's Name: _____

Date of Birth: ____/____/____

Vaccine Name	Dose & Date Given	Given By
DTaP	1	
	2	
	3	
	4	
	5	
(5DTaP, 1 Tdap)	1	
Rotavirus	1	
	2	
	3	
Pneumococcal	1	
	2	
	3	
Meningococcal	1	
	2	
Influenza	1	
	2	
MMR	1	
	2	
Hib	1	
	2	
	3	
Polio	1	
	2	
	3	
	4	
Varicella	1	
	2	
HepB	1	
	2	
	3	
HepA	1	
	2	
HPV*	1	
	<15yrs = 2 doses	2
	≥15yrs = 3 doses	3

MEDICAL NOTES (i.e. allergies, vaccines, reactions, etc.)

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