Emergency Information Form for Children with Arterial Tortuosity Syndrome (ATS)

PERSONAL DETAILS

Name:	Birth Date:	Today's Date:
Home address:	Phone:	
Parent/Guardian:	Emergency contact names/phone numbers & relationships:	
Signature/Consent:		
Primary Language:		

PHYSICIANS

Primary care physician:	Emergency Phone:
	Fax:
Current Speciality physician: Speciality:	Emergency Phone:
	Fax:
Current Speciality physician: Speciality:	Emergency Phone:
	Fax:

PAST PROCEDURES/SURGERIES

Procedure: Date of procedure: Comments:	Procedure: Date of procedure: Comments:
Procedure: Date of procedure: Comments:	Procedure: Date of procedure: Comments:

MEDICATIONS

1.	2.	3.
4.	5.	6.

MANAGEMENT DATA

Allergies: Medications/Foods to be avoided	**And why:**
1.	
2.	
3.	
Activities to be avoided	**And why:**
1.	
2.	
3.	

IMMUNIZATIONS

Dates					**Dates**				
DPT					Hep B				
OPV					Varicella				
MMR					TB satus				
HIB					Other				

COMMENTS ON CHILD, FAMILY,OR OTHER SPECIFIC MEDICAL ISSUES

Name of person who filled out form: Signature:	Relationship to child: Date: