

# Special Needs Alert Program

Division of Public Health  
Emergency Medical Services and Preparedness Section  
100 Sunnyside Road  
Smyrna, DE 19977  
Phone: (302) 223-1720 Fax: (302) 223-1724



Emergency Information Registry for Children with Special Health Care Needs

## What is the Special Needs Alert Program?

The Special Needs Alert Program recognizes children with special healthcare needs for Emergency Medical Services (EMS) providers. It is a pre-hospital notification program for any child who has special emergency care needs. When a child is registered in the Special Needs Alert Program, EMS providers are alerted that the call is for a Special Needs Alert Program child. If medical information is available, providers will be able to give appropriate emergency care for the child and reduce the level of stress often experienced by the family when there is an emergency. In the event of a 911 call, EMS providers, together with the family will determine the child's most important needs.

## Who May Enroll?

Any child (0-21 years of age) with special healthcare needs may enroll. This includes, but is not limited to children with developmental delays, severe behavioral health problems, physical disabilities, special medical technology or equipment, seizure disorder, severe hearing or vision loss, diabetes, Down syndrome, or cerebral palsy. **Participation is strictly on a voluntary basis. You may cancel enrollment at any time. Special Needs Alert Program enrollment is free of charge.**

## How to Enroll Your Child

- Call the Special Needs Alert Program, 302-223-1720
- Download the enrollment instructions and forms via the Special Needs Alert Program website; <http://www.dhss.delaware.gov/dph/ems/emscsnap.html>
- Online Enrollment: Delaware Emergency Preparedness Voluntary Registry for citizens who have special needs website; <http://www.de911assist.delaware.gov/>



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## Special Needs Alert Program Enrollment Instructions

To enroll your child in the Special Needs Alert Program please complete the following:

○ **The Enrollment Form**

- Complete all information requested. If the question is not applicable, please enter N/A.
- Complete the special instructions located in the Medical Information Section. What special instructions will the Emergency Medical Services provider need to treat this child?
- Notify the Special Needs Alert Program of any changes or updates to your child's enrollment information. (i.e. address, telephone, school or daycare changes, or email address changes (302) 223-1720 or via email to: [SNAP@state.de.us](mailto:SNAP@state.de.us).

○ **The Consent Form**

- The Consent Form must be signed and witnessed. The witness may be anyone over the age of 18. The form does not need to be notarized.
- The Consent Form must be updated annually. You will be notified when the annual update is due. If you do not provide the annual update, you may be removed from the program.

○ **The Emergency Information Form**

- The Emergency Information Form is a more in-depth medical form developed by the American Academy of Pediatrics for family use in the event of an emergency. Once completed, a copy of the form should be kept with the child at all times in case of emergency. In the event of an emergency or hospitalization, you can share this form with medical care providers.
- This form should be completed and signed by your child's primary care or specialty physician and updated as changes in information occur.

Once enrolled, the enrollee will not be removed from the Special Needs Alert Program, even after age 21, except if requested information is not updated annually.

Mail, fax or email the forms to the address listed below.

You will be notified from our office when your paperwork is processed.

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**Emergency Medical Services and Preparedness Section  
Office of Preparedness  
100 Sunnyside Road, Smyrna, DE 19977**

[SNAP@state.de.us](mailto:SNAP@state.de.us) Phone: 302-223-1720 Fax: 302-223-1724

**SPECIAL NEEDS ALERT PROGRAM ENROLLMENT FORM**

|   |  |                         |         |
|---|--|-------------------------|---------|
| Child's Name:                                     |  | Name Child Responds To: |         |
| Date of Birth:                                    |  |                         |         |
| Parent(s)/Guardian(s):                            |  |                         |         |
| Home Phone:                                       |  | Work Phone:             |         |
| Cell Phone:                                       |  | Email:                  |         |
| <b>MEDICAL INFORMATION</b>                        |  |                         |         |
| Primary Medical Issue:                            |  |                         |         |
| Other Medical Issues/Diagnoses:                   |  |                         |         |
| Technology/Assisted devices:                      |  |                         |         |
| Special Instructions:                             |  |                         |         |
|   |  |                         |         |
| <b>HOME INFORMATION</b>                           |  |                         |         |
| Street Address:                                   |  |                         |         |
| City:   |  | Zip:                    | County: |
| Home Description:                                 |  |                         |         |
| Best Entrance for EMS Responders:                 |  |                         |         |
| Child's room location:                            |  |                         |         |
| Local Fire Department/Ambulance Service:          |  |                         |         |
| Caregiver's Name (if other than parent/guardian): |  |                         |         |
| Caregiver's Phone:                                |  |                         |         |
| <b>CHILD CARE/SCHOOL/DAY PROGRAM INFORMATION</b>  |  |                         |         |
| Child Care/School/Day Program:                    |  |                         |         |
| Street Address:                                   |  |                         |         |
| City:   |  | Zip:                    | County: |
| Local Fire Department/Ambulance Service:          |  |                         |         |

| <b>FOR INTERNAL USE ONLY</b> |   |                                     |
|------------------------------|---|-------------------------------------|
| Date of Application:         | <input type="checkbox"/> Technology     | <input type="checkbox"/> Medication |
| Date of Enrollment:          | <input type="checkbox"/> Non-Technology | <input type="checkbox"/> Behavioral |
| Date of Home Visit:          | Agency:                                 |                                     |



**DELAWARE  
EMERGENCY MEDICAL SERVICES FOR CHILDREN**

**Consent for Enrollment in the Special Needs Alert Program**

The Delaware Emergency Medical Services for Children program for Children with Special Healthcare/Medical Needs will keep all information provided on the Emergency Information Form and the Home Visit Form confidential, pursuant to the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, and effective Nationwide as of April 14, 2003.

Each Ambulance Service throughout the State of Delaware is required to present you with a Notice of their operation's Privacy Practices, as well as explain to you your rights under the Federal HIPAA laws and guidelines when visiting your home to obtain the above-referenced information for this program. In addition, all emergency medical personnel involved in responding to a medical emergency regarding your child are required to follow all privacy practices and stipulations in place, and cannot discuss, or disseminate in any form, any Protected Health Information (PHI) regarding your child, unless it is imperative to administering care required within the scope of their medical duties where your child is concerned.

By signing below, you acknowledge understanding that the information provided on the attached Enrollment Form may be shared with emergency medical field responders to aid them in providing the necessary emergency medical care to your child and that you have received a copy of the local EMS agency privacy practices.

As a result of the form being used to provide a more complete medical record for your child, there is a potential for this protected health information to be redisclosed to other non-HIPAA covered entities.

Failure to sign this form will not ever result in denial of normal processing of emergency calls or denial of any medically necessary emergency treatment. Please feel free to contact the Ambulance Service at \_\_\_\_\_, the County EMS Agency at \_\_\_\_\_ or the Emergency Medical Services for Children program in the Division of Public Health 302-223-1720 for any questions about the consent form or the Special Needs Alert Program .

*By signing below, I give permission to share the Enrollment Form with necessary emergency medical staff so that they may provide all necessary emergency medical care to my child. I also acknowledge that I have received a copy of this completed consent form and local EMS agency privacy practices. I understand that I may revoke this statement in writing at any time, except to the extent that the organization named above has already taken action on this authorization. To revoke this statement notify in writing your local county EMS agency stating that you wish to withdraw your child from the "Special Needs Alert Program." Include your correspondence to the county EMS agency: the name of the child, the date of birth and the address.*

\_\_\_\_\_  
Parent/Guardian (Print Name)  
or Legal Custodian

\_\_\_\_\_  
Parent/Guardian (Signature)  
or Legal Custodian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to the child

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\_\_\_\_\_  
Witness (Print Name)

\_\_\_\_\_  
Witness (Signature)

\_\_\_\_\_  
Date

This Consent for Enrollment is effective for one year from the date of signature. A new consent and updated health forms will be required to continue in the Special Needs Alert Program after one year.

# Emergency Information Form for Children With Special Needs

|                   |   |  |                                 |                              |
|-------------------|---|--|---------------------------------|------------------------------|
| <b>Patient ID</b> | Today's Date:   | Who is completing this form? You must confirm consent to use this form |                                 |                              |
|                   | Your Name:  | Is this the new form or just an update?                                | <input type="checkbox"/> Update | <input type="checkbox"/> New |
|                   | <b>CONSENT REQUIRED</b>   |  |                                 |                              |
|                   | I (above named person) confirm that parent/ guardian consents to the use of this form <input type="checkbox"/> <b>Consent</b> |  |                                 |                              |
|                   | Patient's Name  | Nickname   |                                 |                              |
|                   | Birthdate   | Address  |                                 |                              |
|                   | Primary language  | Parent/guardian name   |                                 |                              |
|                   | Contact phone Home  | Emergency contact name   |                                 |                              |
|                   | Contact phone Work  | Emergency contact number   |                                 |                              |
|                   | Contact phone Cell  |  |                                 |                              |

|                                   |  |                 |             |   |     |  |
|-----------------------------------|--|-----------------|-------------|---|-----|--|
| <b>Facilities &amp; Providers</b> | Care Provider                            | Provider's name | Specialties | All contact phone numbers (E-mail option) | Fax |  |
|                                   | Primary care                             |                 |             |   |     |  |
|                                   | Specialist-1                             |                 |             |   |     |  |
|                                   | Specialist-2                             |                 |             |   |     |  |
|                                   | Specialist-3                             |                 |             |   |     |  |
|                                   | Specialist-4                             |                 |             |   |     |  |
|                                   | Specialist-5                             |                 |             |   |     |  |
|                                   | Others                                   |                 |             |   |     |  |
|                                   | Primary Pharmacy (branch, phone)         |                 |             |   |     |  |
|                                   | Anticipated primary emergency department |                 |             |   |     |  |
| Anticipated tertiary care center  |  |                 |             |   |     |  |

|                                  |   |
|----------------------------------|---|
| <b>Clinical Baseline</b>         | Diagnoses/problem list (list all) starting with most important    |
|                                  | Baseline physical findings  |
|                                  | Baseline vital signs  |
|                                  | Baseline neurologic status  |
|                                  | Immunologic competency status                                     |
|                                  | Synopsis of clinical status                                       |
|                                  | Medications (doses, purpose)                                      |
|                                  |   |
|                                  | Antibiotic prophylaxis (drug, dose, indication)                   |
|                                  | Significant baseline lab/imaging/diagnostic studies               |
|                                  | Prostheses, appliances, advanced technology devices, life support |
|                                  |   |
|                                  | Allergies: Medications, foods, substances to be avoided and why   |
|                                  | Advanced directives (include date of last review)                 |
| Procedures to be avoided and why |   |

|   |  |  |                   |                           |
|---|--|--|-------------------|---------------------------|
| <b>ED Management</b>  | Describe common presenting problems/findings |  | Suggested studies | Treatment recommendations |
|   | Problem-1                                    |  |                   |                           |
|   | Problem-2                                    |  |                   |                           |
|   | Problem-3                                    |  |                   |                           |
|   | Problem-4                                    |  |                   |                           |
|   | Problem-5                                    |  |                   |                           |
|   | Problems-other                               |  |                   |                           |
| Comments on child, family, or other specific medical issues |  |  |                   |                           |

|                      |                  |   |
|----------------------|------------------|---|
| <b>Immunizations</b> | DPT dates        | Varicella status                              |
|                      | Dtap dates       | Hep B dates                                   |
|                      | OPV or IPV dates | Hep A dates                                   |
|                      | MMR dates        | Meningococcal (Specify which one if possible) |
|                      | HiB dates        | TB status                                     |
|                      | Pneumococcal-7   | HP virus                                      |
|                      | Other            | Other   |

|  |   |  |                        |
|--|---|--|------------------------|
| <b>Disaster Planning &amp; Drills</b>  | Check or enter at least two of the most likely disasters that could affect this patient |  |                        |
|  | <input type="checkbox"/> Power failure  | <input type="checkbox"/> Fire, forest fire   |                        |
|  | <input type="checkbox"/> Hurricane  | <input type="checkbox"/> Infrastructure (roads, communication) damage  |                        |
|  | <input type="checkbox"/> Tornado  | <input type="checkbox"/> Shelter structure damage  |                        |
|  | <input type="checkbox"/> Earthquake   | <input type="checkbox"/> Food and water supply compromise  |                        |
|  | <input type="checkbox"/> Flood  | <input type="checkbox"/> Medication, supplies, equipment compromises   |                        |
|  | <input type="checkbox"/> Tsunami  | <input type="checkbox"/> Nuclear radiation accident (fallout, meltdown, contamination, detonation, etc.)   |                        |
|  | <input type="checkbox"/> Blizzard   | <input type="checkbox"/> Explosion/blast   |                        |
|  | <input type="checkbox"/> Avalanche  | <input type="checkbox"/> Other (e.g., terrorism, biological accident, chemical accident, other weather event)  |                        |
|  | <input type="checkbox"/> Land/mud slide   |  |                        |
| Other (describe)   |   | Other (describe)   |                        |
| Disaster drills reviewed or practiced with patient. Documentation of completed drills and planned dates for future drills. |   |  |                        |
| Date   | Disaster type   | Example drills:<br>verbal review<br>Paper review<br>Table top model<br>Computer simulation<br>Hand on practice<br>Equipment review<br>In home review<br>Alternate electrical power<br>Electric generator use | Describe type of drill |
|  |   |  |                        |
|  |   |  |                        |
|  |   |  |                        |
|  |   |  |                        |
|  |   |  |                        |
|  |   |  |                        |
|  |   |  |                        |

|   |  |              |
|---|--|--------------|
| <b>Medical caregiver or physician's Name: (Print)</b> | <b>Medical caregiver or physician's signature:</b> | <b>Date:</b> |
|---|--|--------------|

