



Digital Portfolio

FOR FAMILIES

**Organizing Health &
Educational Documentation**



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Personal Life

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All About Me

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 **UPLOAD CURRENT PHOTO**

MY NAME IS:

MY AGE IS:

MY BIRTHDAY IS:

MY HOMETOWN:

I LIVE WITH: MOTHER FATHER SIBLINGS GRAND MOTHER GRAND FATHER OTHER:

I LIKE TO:

MY FAVORITE THINGS

SUBJECT:

SPECIAL:

COLOR:

ANIMAL:

SNACK:

DRINK:

ACTIVITY:

SPORT:

VIDEO GAME:

TV SHOW:

MY LEAST FAVORITE SUBJECT IS:

I DO NOT LIKE:

WHEN I GROW UP, I WANT TO BE A:

A FUN FACT ABOUT ME IS:

ONE GOAL FOR THIS YEAR:

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All About Me

Fill in the fields below.

STUDENT SCHOOL INFORMATION

STUDENT NAME:

ID #:

GRADE:

SCHOOL NAME:

SCHOOL ADDRESS:

STATE ID INFORMATION

NAME:

ID #:

EXPIRATION DATE:

ADDRESS:






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Medical History

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-  **UPLOAD CURRENT PHYSICAL**
-  **UPLOAD CURRENT SHOT RECORDS**
-  **UPLOAD DOCTOR'S REPORT OF DIAGNOSIS (IF APPLICABLE)**
-  **UPLOAD ALLERGY INFORMATION (IF APPLICABLE)**
-  **UPLOAD OTHER IMPORTANT INFORMATION**

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Medical History

**Click to upload files that will become attachments.
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 **UPLOAD CURRENT MEDICAL INSURANCE CARDS**

MEDICAL INSURANCE (PRIMARY)

INSURANCE COMPANY NAME:

POLICY #:

CERTIFICATE/GROUP #:

MEDICAL INSURANCE (SECONDARY)

INSURANCE COMPANY NAME:

POLICY #:

CERTIFICATE/GROUP #:

MEDICAL INSURANCE SUPPLEMENTAL

INSURANCE COMPANY NAME:

POLICY #:

CERTIFICATE/GROUP #:

MEDICAL INSURANCE STATE PROVIDED

INSURANCE COMPANY NAME:

POLICY #:

CERTIFICATE/GROUP #:

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Medical History

MEDICATIONS

 **UPLOAD MEDICATION INFORMATION (IF APPLICABLE)**

PHARMACY INFORMATION

PHARMACY NAME:

PHARMACY PHONE:

PHARMACY ADDRESS:

MEDICATION INFORMATION

MEDICATION:

DOSE:

FREQUENCY:

MEDICATION:

DOSE:

FREQUENCY:

MEDICATION:

DOSE:

FREQUENCY:

MEDICATION:

DOSE:

FREQUENCY:

MEDICATION:

DOSE:

FREQUENCY:

MEDICATION:

DOSE:

FREQUENCY:

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Medical History

THERAPY OR ADDITIONAL SERVICES



UPLOAD THERAPY OR ADDITIONAL SERVICES INFORMATION (IF APPLICABLE)

SERVICE:

PROVIDER:

ADDRESS:

PHONE:

EMAIL:

WEBSITE:

FREQUENCY:

SERVICE:

PROVIDER:

ADDRESS:

PHONE:

EMAIL:

WEBSITE:

FREQUENCY:

SERVICE:

PROVIDER:

ADDRESS:

PHONE:

EMAIL:

WEBSITE:

FREQUENCY:

SERVICE:

PROVIDER:

ADDRESS:

PHONE:

EMAIL:

WEBSITE:

FREQUENCY:

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Medical History

ADAPTIVE/MEDICAL EQUIPMENT

 [UPLOAD ADAPTIVE/MEDICAL EQUIPMENT INFORMATION \(IF APPLICABLE\)](#)

EQUIPMENT TYPE:

CONTACT/SERVICE INFORMATION:

SERIAL NUMBER:

WARRANTY INFORMATION:

EQUIPMENT TYPE:

CONTACT/SERVICE INFORMATION:

SERIAL NUMBER:

WARRANTY INFORMATION:

EQUIPMENT TYPE:

CONTACT/SERVICE INFORMATION:

SERIAL NUMBER:






WARRANTY INFORMATION:

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Educational Documentation

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-  [UPLOAD CURRENT EVALUATIONS](#)
-  [UPLOAD CURRENT IEP / IFSP / 504](#)
-  [UPLOAD IPE \(EMPLOYMENT PLAN\)](#)
-  [UPLOAD PROGRESS REPORTS / REPORT CARDS](#)
-  [UPLOAD EXAMPLES OF STUDENT WORK](#)

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Transition Age/ Age of Majority Plan

 DECISION MAKING DOCUMENTATION

LOCATION OF GUARDIANSHIP/POA/DECISION MAKING DOCUMENTS *(Where can they be found?)*

RESIDENTIAL/PLACEMENT INFORMATION *(if outside the home)*

LOCATION:

WORK/POSTSECONDARY SCHOOL INFORMATION

LOCATION:

SCHEDULE:

SUPERVISOR CONTACT INFORMATION:

SALARY:

ACCOMMODATIONS AND SUPPORTS INFORMATION

 UPLOAD IPE (EMPLOYMENT PLAN)

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Transition Age/ Age of Majority Plan

 **UPLOAD DRIVERS LICENSE/STATE ID/MILITARY ID**

DRIVER'S LICENSE/STATE ID INFORMATION

STATE:

LICENSE/ID #:

EXPIRATION:

TRANSPORTATION INFORMATION

PERSONAL CAR INFORMATION:

MAKE/MODEL:

REGISTRATION AND INSURANCE INFORMATION:

OTHER TRANSPORTATION INFORMATION

DRIVER CONTACT INFORMATION:

PUBLIC TRANSPORTATION ROUTE/SCHEDULE:

VOTER INFORMATION

VOTER STATUS:

POLL LOCATION:

ADDITIONAL INFORMATION:

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State Disability Services

MEDICAID WAIVERS

AGENCY NAME:

POINT OF CONTACT:

BENEFICIARY ID #:

VOCATIONAL REHABILITATION (VR) AGENCY

AGENCY NAME:

POINT OF CONTACT:

CENTER FOR INDEPENDENT LIVING (CIL)

AGENCY NAME:

POINT OF CONTACT:

HOUSING

AGENCY NAME:

POINT OF CONTACT:

 **UPLOAD ANY RELATED DOCUMENTS**

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Financial Life

BANK/CHECKING/SAVING ACCOUNT INFORMATION
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LIFE INSURANCE
SUPPLEMENTAL SECURITY INCOME (SSI)
SOCIAL SECURITY DISABILITY INCOME (SSDI)
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Financial Life

BANKING INFORMATION

BANK NAME AND CONTACT INFORMATION

BANK NAME: WEBSITE:

ACCOUNT TYPE:

ACCOUNT NUMBER:

ROUTING NUMBER:

BANK NAME AND CONTACT INFORMATION

BANK NAME: WEBSITE:

ACCOUNT TYPE:

ACCOUNT NUMBER:

ROUTING NUMBER:

ABLE ACCOUNT INFORMATION

ACCOUNT NAME:

ACCOUNT NUMBER:

PHONE NUMBER: WEBSITE:

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Financial Life

**Click to upload files that will become attachments.
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 **UPLOAD LIFE INSURANCE DOCUMENTS**

LIFE INSURANCE COMPANY

NAME AND CONTACT INFORMATION:

POLICY NUMBER:

SUPPLEMENTAL SECURITY INCOME (SSI) / SOCIAL SECURITY DISABILITY INCOME (SSDI)

 **UPLOAD SSI / SSDI DOCUMENTATION**

LOCAL SOCIAL SECURITY ADMINISTRATION OFFICE ADDRESS:

PHONE NUMBER:

CURRENT SSI BENEFIT AMOUNT:

CURRENT SSDI BENEFIT AMOUNT:

 **UPLOAD SPECIAL NEEDS TRUST DOCUMENTS**

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Emergency Contact Info

PRIMARY EMERGENCY CONTACT

SECONDARY EMERGENCY CONTACT

NEXT OF KIN

DOCTOR

DENTIST

ATTORNEY

STATE PARENT TRAINING AND INFORMATION CENTER

CAREGIVER/BABYSITTER

RESPIRE PROVIDER

SUPPORTED DECISION MAKING CONTACT

OTHER

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Emergency Contact Information

Fill in the fields below.

PRIMARY CONTACT INFORMATION

NAME:

ADDRESS:

PHONE NUMBER:

SECONDARY CONTACT INFORMATION

NAME:

ADDRESS:

PHONE NUMBER:

NEXT OF KIN

NAME:

ADDRESS:

PHONE NUMBER:

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Emergency Contact Information

Fill in the fields below.

DOCTOR'S INFORMATION

NAME:

ADDRESS:

PHONE NUMBER:

DENTIST'S INFORMATION

NAME:

ADDRESS:

PHONE NUMBER:

ATTORNEY

NAME:

PHONE NUMBER:

ADDRESS:

TYPE OF ATTORNEY:

SERVICES PROVIDED:

STATE PARENT TRAINING AND INFORMATION CENTER

NAME:

ADDRESS:

PHONE NUMBER:

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Emergency Contact Information

Fill in the fields below.

CAREGIVER/BABYSITTER

NAME:

ADDRESS:

PHONE NUMBER:

RESPITE PROVIDER

NAME:

ADDRESS:

PHONE NUMBER:

SUPPORTED DECISION MAKING CONTACT

NAME:

ADDRESS:

PHONE NUMBER:

OTHER

NAME:

ADDRESS:

PHONE NUMBER:

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