Personal Emergency Plan

My Safety, My Responsibility, My Plan

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The ***Personal Emergency Plan*** is made up of forms that contain all the information needed in case of an emergency.

It includes the following sections:

- Medical Information – **Form A**
- Immunizations and Medications – **Form B** (**B_1** and **B_2**)
- Daily Living/Mobility Needs – **Form C**
- Communication/Emotional Needs – **Form D**
- Contact Information – **Form E**
- Escape Plan (floor plan) – **Form F**
- Steps in an Emergency – **Form G**
- My Documents – **Form H**
- My Health Summary

Forms A, B, C, D, E, and **H** should be completed and kept in a **folder** that will go into your ***Go-bag***. They should go with you in case you need to leave your home.

Forms F and **G** should be hung in your home where you can see them easily.

My Health Summary is a one-page summary of your health needs. Keep it with you at all times, like in your wallet or backpack. Remember to keep all information up to date!

To help you complete all these forms, go to the ***My Safety, My Responsibility, My Plan training curriculum*** or review ***all*** the ***videos*** on the website.

Name _____ Date of Birth _____
Address _____
_____
Phone Number _____ E-mail _____
Contact Person or Guardian/Phone Number _____
_____
Agency providing services _____

Medical Information

Primary Physician _____Phone Number _____Fax_____
Address _____
_____
Medicaid Number _____
Medicare Number _____
Private Insurance Name _____Policy Number _____
Hospital _____
Pharmacy _____Phone Number_____Fax_____
address_____
Blood Type _____

Medical Conditions:

Regular Medical Treatments:

Check if you are afraid of Needles _____

Allergies and Sensitivities/Reactions:

Special Diet:

Medical Devices Needed:

Type	Vendor/Contact	Phone Number	Batteries? Electricity?
Type	Vendor/Contact	Phone Number	Batteries? Electricity?

People who know how to work device _____

Name _____ Date of Birth _____
Address _____

_____
Phone Number _____E-mail _____
Contact Person or Guardian/Phone Number _____
Agency providing services _____

Immunizations

Type Dates
Recent_____
_____
_____
_____
Past_____
_____
_____
_____

Medications

Check:
Medications are taken by me. ____ Medications are given to me by someone else. ____
Pharmacy Name _____**Phone number** _____

Name/Dosage How Much How Often When Taken How Taken
_____
Doctor Name on label_____
Check if needs refrigeration _____

Name/Dosage How Much How Often When Taken How Taken
_____
Doctor Name on label_____
Check if needs refrigeration _____

Name/Dosage How Much How Often When Taken How Taken
_____
Doctor Name on label_____
Check if needs refrigeration _____

Name/Dosage How Much How Often When Taken How Taken
_____
Doctor Name on label_____
Check if needs refrigeration _____

Name ____

Medications – Continued

Pharmacy Name ______________________________ Phone Number ________________

Name/Dosage How Much How Often When Taken How Taken
____
Doctor Name on label____
Check if needs refrigeration _________

Name/Dosage How Much How Often When Taken How Taken
____
Doctor Name on label____
Check if needs refrigeration _________

Name/Dosage How Much How Often When Taken How Taken
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Doctor Name on label____
Check if needs refrigeration _________

Name/Dosage How Much How Often When Taken How Taken
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Doctor Name on label____
Check if needs refrigeration _________

Name/Dosage How Much How Often When Taken How Taken
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Doctor Name on label____
Check if needs refrigeration _________

Name/Dosage How Much How Often When Taken How Taken
____
Doctor Name on label____
Check if needs refrigeration _________

Name/Dosage How Much How Often When Taken How Taken
____
Doctor Name on label____
Check if needs refrigeration _________

Name _____

Daily Living / Mobility Needs

Mobility Equipment Needed:

Type	Vendor	Phone Number	Batteries? Electricity?
Type	Vendor	Phone Number	Batteries? Electricity?

People who know how to work equipment _____

Daily living equipment needed:

Type	Vendor	Phone Number	Batteries? Electricity?
Type	Vendor	Phone Number	Batteries? Electricity?

People who know how to work equipment _____

I have a service animal named _____who must stay with me.
License or ID Number: _____
Vaccinations: _____

I need **HELP** with:

To **HELP** me eat, I need:

SAFETY PRECAUTIONS

Name _____

Communication / Emotional Needs

I understand _____ I can read words ___ pictures ___ Braille ___
I use sign language _____ I use hand/head movements _____

I use a Communication Device:
Type _____
Vendor Name/Phone _____
Batteries/Electricity: _____

I have a hearing problem _____ I have a visual impairment _____

I wear eyeglasses ___ contact lenses ___ hearing aids ___ dentures ____

During an emergency I may **FEEL** or **ACT**:

To help **CALM** me, I would like a first responder to:

I need to bring _____with me to help me feel better.

Contact Information

Name _____ Date of Birth _____
Address _____

_____
Phone Number _____E-mail _____
Agency providing services _____

Contact Person _____
Phone Number _____E-mail address _____
Address _____

Out-of-state Contact _____
Phone Number _____E-mail address _____
Address _____

Support Persons
Name _____
Location _____
Phone Number _____E-mail address_____

Name _____
Location _____
Phone Number _____E-mail address_____

Name _____
Location _____
Phone Number _____E-mail address_____

Name _____
Location _____
Phone Number _____E-mail address_____

Name _____

Escape Plan

Where I will meet outside my home _____

Who will help me _____

Steps In An Emergency

This sheet tells you what you must do if you have to leave your home. Do not use it if there is a fire in your home.
In case of fire, GET OUT FAST!

Name _____

1. **I will know there is an emergency because:**
   _____
   _____
   _____

2. **I will call (local contact/support person):**
   _____
   _____

3. **For transportation I will call:** _____
   _____

4. **Let others know how they can help me.**
   _____
   _____
   _____

5. **Take Go-Bag with *Personal Emergency Plan* folder in it.**

6. **Go to:** _____

7. **Call out-of-area contact:** _____
   _____

IF I AM HURT
I WILL CALL 911

My Documents

The following copies of documents are enclosed:

1.

2.

3.

4.

5.

6.

MY HEALTH SUMMARY

NAME: **Address:**
Phone Number(s):
Date of Birth:
Blood Type: **Weight:** **Safety Alert:**

CONTACT Name	Phone Number	Address
LEGAL GUARDIAN:		

MEDICAL INSURANCE	Policy Number	Group Number

PHYSICIAN(S)	Phone Number	Address	Fax Number

ALLERGIES / REACTION

MEDICAL CONDITIONS/DIAGNOSIS/BASELINE DATA

ONGOING MEDICAL TREATMENTS/LOCATION/ALTERNATE SITE

IMMUNIZATIONS
Type/Dates

CURRENT MEDICATIONS
Medication/Dosage/ How Much/How Often/When Taken/ Doctor who Prescribed

Pharmacy/Address:
Pharmacy Phone Number: **Fax Number:**

MEDICAL/ MOBILITY AIDS/DEVICES			
Name	Vendor	Phone Number	Electricity/Batteries?

DAILY LIVING AIDS/SPECIAL INSTRUCTIONS/SERVICE ANIMAL

COMMUNICATION DEVICES			
Name	Vendor	Phone Number	Electricity/Batteries?