

Personal Emergency Plan

My Safety, My Responsibility, My Plan

**Marilyn Vitale
Westchester Institute for Human Development**

**Developed through corporate funding from Entergy and with the support of
the Westchester County Department of Emergency Services and the
American Red Cross in Westchester County**



Copyright © 2010

Personal Emergency Plan

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 (B₁ and B₂)**
- 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

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/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 _____

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?