

## EMERGENCY PREPAREDNESS FORM

# MEDICAL INFORMATION AND EMERGENCY HEALTH CARE PLAN



This **MEDICAL INFORMATION AND EMERGENCY HEALTH CARE PLAN** is intended to communicate pertinent medical information and how an emergency responder or other person could assist you in case of an emergency or natural disaster. This form should be completed in conjunction with the **MEDICAL EMERGENCY WALLET CARD**. You should keep this form with a copy of your **MEDICAL EMERGENCY WALLET CARD** on you at all times and keep an extra copy of both of these items in your **GO BAG**. You should update this form every six months or when there is a change in your health status/condition(s).

Date of last review and update of this form:

\_\_\_\_/\_\_\_\_

### PERSONAL DATA

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Relationship: \_\_\_\_\_

### MEDICAL/HEALTH HISTORY

(Check all that apply)

- |  |   |  |
|--|---|--|
| <input type="radio"/> Allergies              | <input type="radio"/> Fainting/periods of unconsciousness | <input type="radio"/> Muscle aches           |
| <input type="radio"/> Arthritis              | <input type="radio"/> Hearing loss                        | <input type="radio"/> Rash                   |
| <input type="radio"/> Asthma                 | <input type="radio"/> Heart disease                       | <input type="radio"/> Seizures               |
| <input type="radio"/> Bladder/bowel issues   | <input type="radio"/> Heartburn/acid reflux               | <input type="radio"/> Shortness of breath    |
| <input type="radio"/> Cancer                 | <input type="radio"/> High blood pressure                 | <input type="radio"/> Stomach problems       |
| <input type="radio"/> Diabetes               | <input type="radio"/> High cholesterol                    | <input type="radio"/> Urinary issues         |
| <input type="radio"/> Dizziness              | <input type="radio"/> Kidney disease                      | <input type="radio"/> Visual impairment      |
| <input type="radio"/> Easy bleeding/bruising | <input type="radio"/> Lung disease                        | <input type="radio"/> Other (specify): _____ |
| <input type="radio"/> Fevers                 | <input type="radio"/> Migraines                           | _____  |

List any medical conditions that you are currently treating or have been treated for in the past (stroke, heart attack, etc.): \_\_\_\_\_

See my **MEDICAL EMERGENCY WALLET CARD** for the following information: doctor's name, phone number, and preferred hospital; list of allergies; and list of medications.

### INFORMATION ABOUT MY MEDICAL EQUIPMENT AND DEVICES

(Examples: pacemaker, insulin pump, ventilator, CPAP, oxygen, baclofen pump, vagal nerve stimulator, prosthetics, assistive technology)

Device type: _____	Device type: _____	Device type: _____
Doctor: _____	Doctor: _____	Doctor: _____
Directions for use: _____	Directions for use: _____	Directions for use: _____
_____	_____	_____
_____	_____	_____

(continued on back)

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### DAILY LIVING AND MOBILITY SKILLS

**Level of independence (check one):**

- Independent:** I can complete all daily living activities on my own.
- Stand-by assistance:** I need assistance related to mobility tasks and some daily living activities.
- Partial assistance:** I need assistance with some daily living activities.
- Total assistance:** I need assistance with all daily living activities.

**Mobility (check one):**

- Ambulatory**                       **Bed-ridden**
- Wheelchair or scooter**       **Completely immobile**

**Sensory Impairments (check all that apply):**

- Vision**                                       **Speech**
- Hearing**                                       **Cognitive**

**Communication (check all that apply):**

- I can communicate using **my voice (words)**.
- I can communicate using **sign language**.
- I can communicate using a **communication board**.
- I can **read lips**.
- I need an **interpreter** for (specify language): \_\_\_\_\_
- I use a **hearing aid** and/or **hearing loop**.
- I use a **tablet** or **iPad**.
- I use a **switch device** for communication.

**Other important issues, comments, or instructions:** \_\_\_\_\_

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### PREFERENCES AND CONSIDERATIONS

**Preferred method of transport in non-emergency situations:****Possible method(s) of transport in an emergency:****Special training needed for working with me:** (e.g. "I have a ventilator and need a person trained to maintain a ventilator.")**Special instructions for first responders and caregivers:** (e.g. triggers, signs/symptoms, interventions)**Considerations if I fail to respond to medical treatment:** (e.g. "Consider medications I have prescribed for 'as needed' situations.")**Considerations regarding my personal preferences:** (e.g. "My body temperature runs lower, so please keep a blanket and hat on me at all times.")