My Emergency Care Plan

About Me

Name

Birthday

Health Insurance

Blood Type

My Support Person

Name

Phone

Email

My Conditions

Any disabilities or other health conditions:

Any special care instructions:

More space on next page if needed

I Communicate By: (Check all that apply)

Talking Writing or typing

Using sign language Using a device

Pointing to words Pointing to pictures

Using gestures/body

Other ways I communicate:

I understand these languages:

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Pet or service animal 7
Home groceries / meal prep 7

Jse the space below to provide more information about your disabilities/health conditions	
Jse the space below to provide more special care instructions	

Medical Profile

My Equipment / Devices

(Check all that apply)

Braces/orthotics Communication devices Glasses Other

Hearing aids Home oxygen Insulin pump

Reading device/aid Service animal Suction

Walker/cane Wheelchair Writing device/aid

Allergies

Type Food*	Reactions / Symptoms
Medicines	
Other	

*Special Diet: If yes, explain below:

Yes No

Immunizations Received

COVID-19 (Fully vaccinated) COVID-19 (Partially vaccinated)

Chickenpox (Varicella) Diphtheria, tetanus, &whooping cough (pertussis) (DTaP)

Haemophilus influenzae type b (Hib) Influenza (current season)

Measles, mumps, rubella (MMR) Polio (IPV) (between 6 through 18 months)

Pneumococcal (PCV) Hepatitis A (HepA)

Hepatitis B (HepB)

List any other vaccinations:

Pharmacies

Name Name

Address Address

Phone # Fax # Phone # Fax #

Medical Profile

Medications

Medication name:	Dosage and Frequency:
How I take it:	Why I take it:
Medication name:	Dosage and Frequency:
How I take it:	Why I take it:
Medication name:	Dosage and Frequency:
How I take it:	Why I take it:
Medication name:	Dosage and Frequency:
How I take it:	Why I take it:
Medication name:	Dosage and Frequency:
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Medication name:	Dosage and Frequency:
How I take it:	Why I take it:
Medication name:	Dosage and Frequency:
How I take it:	Why I take it:
Medication name:	Dosage and Frequency:
How I take it:	Why I take it:

Medical Profile

Physicians / Providers

Name:	Name:
Specialty:	Specialty:
Phone #:	Phone #:
Name:	Name:
Specialty:	Specialty:
Phone #:	Phone #:
Name:	Name:
Specialty:	Specialty:
Phone #:	Phone #:
Name:	Name:
Specialty:	Specialty:
Phone #:	Phone #:
	Surgical History
	(Start with most recent procedure)
Туре:	Туре:
When:	When:
Туре:	Туре:
When:	When:
Туре:	Туре:
When:	When:
Туре:	Туре:
When:	When:

Personal Profile

Advance Care Directive

- __ I have signed an advance health care directive, designated a health care agent and gave that person a copy of the directive.
 - My designated health care agent is:
- I do not have an advance health care directive but want to name someone to be my surrogate decision maker for health care decisions.

My surrogate decision maker for health care is:

Person(s) to Contact About My Health:

(Examples: aides, family, neighbor, or friend)

I Need Help With:

(Check all that apply) Eating Drinking Washing Bathroom Dressing

Other things I need help with:

How I Express Myself

I might get upset from: (examples: noises, lighting, being touched, smells, face masks)

When I am anxious or stressed, I feel better when:

When I am hurt or sick, I feel better when:

When I am in pain, I show it by:

Personal Profile

My Strengths:

(What comes easy for me or something I am proud of):

My Challenges:

(Examples: communication, feeding, learning, mobility, social, energy, behavior):

Person(s) to Contact About My Pet or Service Animal:

(Examples: family member, aide, neighbor or friend. Include name(s) and phone number(s).)

Person(s) to Contact About My Home Groceries / Meal Prep:

(Examples: family member, aide, neighbor or friend. Include name(s) and phone number(s).)



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