EMERGENCY PREPAREDNESS for
PEOPLE WITH DISABILITIES
AND THEIR FAMILIES

"The Take and Go Emergency Book"

Developed by Individuals with Disabilities and Their Families
In collaboration with the
Office for Citizens with Developmental Disabilities

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THE TAKE AND GO EMERGENCY BOOK

For

Paste
Picture
Here

I communicate by:

___ Speaking
___ Using sign language
___ Using a communication device
___ Using gestures

My Name

Date Prepared
Personal Information

Name: __________________________________________
Address: _________________________________________
City: ___________________ State: _______ Zip: ________
Telephone: (____) __________ Work Phone: (____) ______
Cell Phone: (____) __________ E-mail: _______________________
Date of Birth: _______________ SS#: ____________

These are my family members: Contact #s:
Father: ________________________
Mother: ________________________
Spouse: ________________________
Brother(s): ____________________
Sister(s): ____________________
Grandparent(s): _______________
Other Family: __________________

These are people that are important to me: Contact #s:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

My History:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Medical Information

My legal status is (circle one): Minor Interdicted Competent Major

Blood Type: ____________________

Cautions for Emergency Medical Technicians: ____________________________

My emergency contact person is: ________________________________________

My insurance is: ______________________________________________________

Medicaid/Medicare #: _________________________________________________

Primary Care Physician: ________________________________________________

Address: __________________________ Phone: _____________________________

_________________________ Pager: ________________________________

Hospital: ____________________________________________________________

Secondary Care Physician: _____________________________________________

Address: __________________________ Phone: _____________________________

_________________________ Pager: ________________________________

Hospital: ____________________________________________________________

I use Durable Medical Equipment: ________________________________

Medical Equipment Brand/Where Purchased: _____________________________

I use Life Support Equipment: _________________________________________

Life Support Equipment Brand/Where Purchased: _________________________

I have the following conditions and have had these procedures: __________

__________________________________________________________________________
Health and Safety

Medical Conditions:


Medications:


Pharmacy and Prescription #s:


Note: Bring Pill Bottles

Allergies:


Important things you need to know before you help me:


This is the type diet (regular, diabetic, salt restricted) that I am on and how my food is prepared (regular, chopped, pureed):


This is how I eat:
This is how I drink:

This is how I take my medication:

I do not receive any supports and services; these are the people who know me best:

These are the programs that assist me:

This is my Support Coordination Agency:

- Support Coordinator's Name:
- Address:
- Contact Numbers:
- E-mail: Fax: Cell Phone:

This is my Provider Agency:

- My contact there is:
- Address:
- Contact Numbers:
- E-mail: Fax: Cell Phone:

This is where I go to School:

- Address:
- Contact Numbers:
I have this plan(s) (circle all that you have): IEP  ITP  504


This is where I Work:

Supervisor’s Name: ________________________________

Address: _________________________________________

Contact Numbers: __________________________________

E-mail: ___________________  Fax #: ___________________  (For each agency)

Web address and cell phone: ______________________________

This is where I Bank: __________________________________

Contact Numbers: ____________________________________
Likes and Dislikes

Things that I like (people, places, things, activities that create excitement, happiness and engagement):


This is how I show I’m happy:


Things that I do not like (people, places, things, and situations that cause upset, anger, sadness, and/or frustration):


This is how I show my anger:


If I’m scared, this is how I react:


When I am scared, I need you to:


I communicate best when (gesturing, speaking, behaving a certain way, using a communication device, using sign language):


I understand best when (shown, shown and told how, using hand-over-hand techniques):

________________________________________________________________________

________________________________________________________________________

I need help with: __________________________________________________________________________

________________________________________________________________________

What people need to know about me to keep me healthy, safe and happy: __________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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Note: Booklet format developed by people with disabilities and family members in collaboration with the Office for Citizens with Developmental Disabilities (05/10/06).
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