<table>
<thead>
<tr>
<th>FREE SPACE (for your custom message)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can’t speak but I can hear and understand you.</td>
</tr>
<tr>
<td>My technology needs to be charged.</td>
</tr>
<tr>
<td>My vital information is on the back on this page.</td>
</tr>
<tr>
<td>Please contact my family.</td>
</tr>
<tr>
<td>Ask me questions if you need to, but please wait patiently for my replies.</td>
</tr>
<tr>
<td>I will point to where I hurt.</td>
</tr>
</tbody>
</table>

- **Who**: You, yours, Broken, Need/Want, Blanket, Disaster, Home, Walker
- **Where**: She, her, hers, Burn, Rescue, Clothes, Emergency, Hospital, Wheelchair
- **What**: He, his, him, Choke, Spell, Cold, Family, Sick, Wind
- **When**: They, them, their, Communicate, Talk, Damage, Fire, Pets, Worried
- **Why**: We, ours, Evacuate, Understand, Danger, Flood, Shelter, Worse/Worst
- **How**: YES, Hurt/Injure, Wait, Communication Device, Heat/Hot, Seizure, NO

**Emergency Communication 4 ALL**

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1. NAME __________________________
   DOB __________________________
   Address __________________________
   Cell Phone __________________________
   Home Phone __________________________
   Email __________________________

2. EMERGENCY CONTACT
   Name __________________________
   Address __________________________
   Cell Phone __________________________
   Home Phone __________________________
   Relation __________________________

3. 2ND EMERGENCY CONTACT
   Name __________________________
   Address __________________________
   Cell Phone __________________________
   Home Phone __________________________
   Relation __________________________

4. DOCTOR
   Name __________________________
   Address __________________________
   Phone __________________________

5. HEALTH INSURANCE
   - Private
   - Medicare
   - Medicaid
   - Other __________________________
   Policy Number __________________________
   Date Issued __________________________

6. PRESCRIPTION MEDICATIONS
   Name & Dosage __________________________
   Name & Dosage __________________________
   Name & Dosage __________________________
   Name & Dosage __________________________
   Name & Dosage __________________________

7. OVER THE COUNTER DRUGS
   1) __________________________
   2) __________________________

8. PHARMACY NAME
   Contact Person __________________________
   Phone __________________________

9. ALLERGIES [complete list] __________________________

10. RELEVANT MEDICAL HISTORY [brief] __________________________

11. SUPPORT AGENCY [if applicable] __________________________

12. MEDICAL EQUIPMENT/TECHNOLOGY SUPPLIER __________________________

13. EQUIPMENT/SUPPORT NEEDED FOR INDEPENDENCE
   Personal Assistance Services
   Name __________________________
   Phone __________________________
   Allotted Hours __________________________
   Mobility/Transferring __________________________
   Communication __________________________
   Hygiene/Toileting/Vision __________________________
   Telephone Use __________________________
   Finances/Writing __________________________
   Cooking __________________________
   Eating and Diet __________________________
   Transportation __________________________
   Service Animals __________________________

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