

Emergency Contact Lists



Flood



Fire



Lightning



Terrorism



Heatwave



Snowstorm



Hurricane



Bombing

Tab 5

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Neighbor Contact List



Updated ___/___/___

Person	Address	Cell Phone	Home Phone	Work Phone	Email
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Source: June Isaacson Kailes, Disability Consultant, Playa del Rey, California and the Center for Disability Issues and the Health Profession, Western University of Health Sciences, Pomona, CA www.cdihp.org

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Your name: _____

Date last updated: ___/___/___

Emergency Telephone List

EMERGENCY - DIAL 911

Name	Number
Police Department	
Fire Department	
Other:	
Other:	

FAMILY

Name	Number

FRIENDS / CO-WORKERS

Name	Number

DOCTORS

Name	Number

OTHERS

Name	Number

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Your name: _____

Date last updated: ___/___/___

Emergency Information List

My Information

Name: _____

Birth date: _____

Address: _____

Cell phone: _____

Home phone: _____

Local Emergency Contact:

Name: _____

Address: _____

Cell phone: _____

Home phone: _____

Work phone: _____

Out of Town Emergency Contact:

Name: _____

Address: _____

Cell phone: _____

Home phone: _____

Work phone: _____

Support Group Members:

Support Group Member #1:

Name: _____

Cell phone: _____

Home phone: _____

Work phone: _____

Support Group Member #3:

Name: _____

Cell phone: _____

Home phone: _____

Work phone: _____

Support Group Member #2:

Name: _____

Cell phone: _____

Home phone: _____

Work phone: _____

Support Group Member #4:

Name: _____

Cell phone: _____

Home phone: _____

Work phone: _____

Your name: _____

Date last updated: ___/___/___

How best to communicate with me:

Other information:

Your name: _____

Date last updated: ___/___/___

Medical Information List

Primary physician: _____

Telephone: _____

Address: _____

Specialist #1 name: _____

Telephone: _____

Address: _____

Specialist #2 name: _____

Telephone: _____

Address: _____

Hospital affiliation: _____

Type of health insurance: _____

Policy number: _____

Blood type: _____

Allergies and sensitivities: _____

Medication name:	Dosage and time taken:
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

Your name: _____

Date last updated: ___/___/___

Specific medical conditions:

Physical limitations:

Adaptive equipment and vendors' phones:

Communication difficulties:

Cognitive difficulties:

Mental health condition:

Other:

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Emergency Information (ID) Cards

Your name: _____

Your address: _____

Cell phone: _____

Home phone: _____

Emergency contact name & phone:

Diagnosis:

Medications: What it is for & dose

Medical technology / equipment
used:

Critical Contacts

Contact name: _____

Contact phone: _____

Other info: _____

Doctor name and phone number:

Hospital: _____

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Emergency Information (ID) Cards

Your name: _____

Your address: _____

Cell phone: _____

Home phone: _____

Emergency contact name and phone:

Diagnosis:

Medications: What it is for and dose

Medical technology and equipment:

Critical Contacts

Contact name: _____

Contact phone: _____

Other info: _____

Doctor name & phone number:

Hospital: _____

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