

Individual Disaster Plan

Name:

Address:

Street _____ **City:** _____ **Phone:** _____

Planning Team

Family

Name: _____ Address _____ Phone: _____

Caregiver

Name: _____ Address _____ Phone _____

Neighbors

Name: _____ Address _____ Phone _____

Service Providers

Agency: _____ Address: _____ Phone: _____

Agency: _____ Address: _____ Phone: _____

Agency: _____ Address: _____ Phone: _____

Emergency Information

Emergency Contacts: (List one emergency contact that live more than 100 miles from your home)

Name: _____ Address _____ Phone: _____

Name: _____ Address _____ Phone: _____

Name: _____ Address _____ Phone: _____

Medical Information

Primary Care Physician

Name: _____ Address _____ Phone: _____

Other Medical Providers

Name: _____ Address _____ Phone: _____

Name: _____ Address _____ Phone: _____

Name: _____ Address _____ Phone: _____

Health Insurance Provider: _____ Health Insurance Card Information _____

Medical Information

Medical Condition or Ailments

- _____
- _____
- _____

Medications

Name of Medication: _____ Dosage _____

When Taken _____ Condition Used For : _____

Physician Who Prescribed _____ Physician's Phone: _____

Name of Medication: _____ Dosage _____

When Taken _____ Condition Used For: _____

Physician Who Prescribed _____ Physician's Phone: _____

Name of Medication: _____ Dosage _____

When Taken _____ Condition Used For: _____

Physician Who Prescribed _____ Physician's Phone: _____

Name of Medication: _____ Dosage _____

When Taken _____ Condition Used For: _____

Physician Who Prescribed _____ Physician's Phone: _____

Medical Information

Allergies: _____

Communication Difficulties: _____

Cognitive Difficulties _____

Adaptive Equipment Required (Wheelchairs, Oxygen, Hearing Devices, Walkers, Etc.). Include serial number of devices.

Emergency Supplies

Location of Supplies _____

Check Supplies Included in Supply Kit:

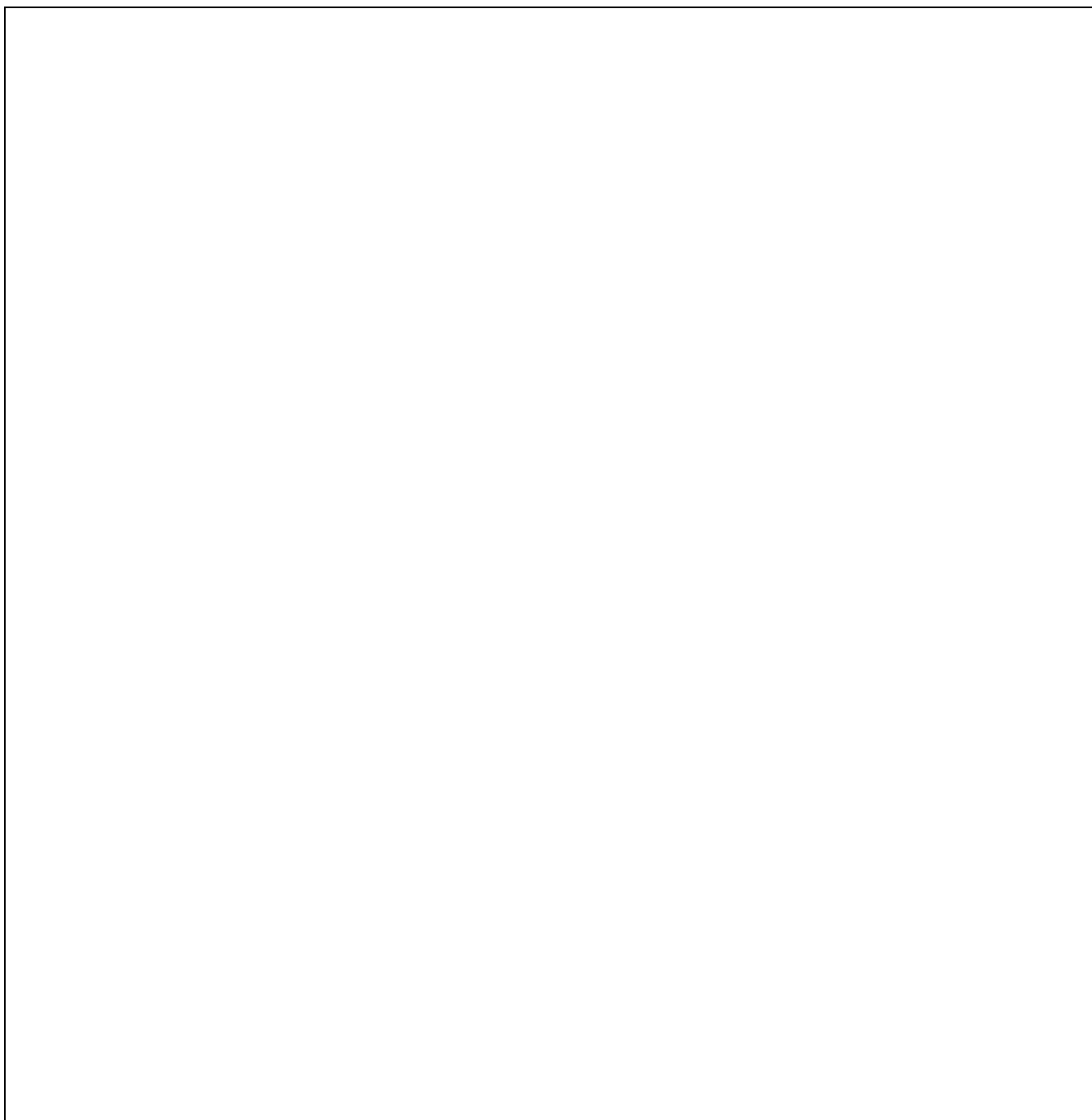
- First Aid Kit
 - Prescription Drugs
 - Eyeglasses
 - Hearing Aid Batteries
 - Flashlight
 - Wheel Chair Batteries
 - Medical Insurance
 - Medicare Card
 - List of Physicians, Family, Friends to be Notified
 - List Style and Serial Numbers of Medical Devices
 - Water: 1 gallon per person per day.
 - Non Perishable Food
 - Can Opener
 - Utensils
 - Battery Powered Radio
 - Change of Clothing
 - Rain Gear
 - Sturdy Shoes
 - Blanket or Sleeping Bag
 - Extra Keys
 - Cash, Credit Card, Phone Card, Change
 - Personal Hygiene Supplies
 - Insurance Agent's Name and Phone Number
 - Other _____
-

Home Layout

Illustrate the layout of your home.

Mark in red all exits and escapes route.

Mark in **black** where emergency supplies are located

A large, empty rectangular box with a thin black border, intended for the user to draw and illustrate the layout of their home. The box is currently blank.