My Emergency Care Plan

Click to insert photo

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:

Inside Pages:

Medical Profile

My Equipment/Devices..... 3

Allergies..... 3

Immunizations 3

Pharmacies 3

Medications 4

Physicians / Providers 5

Surgical History 5

Personal Profile

Advance Care Directive 6

Person(s) to contact about my Health 6

I need help with 6

How I express myself 6

My strengths..... 7

My challenges 7

Person(s) to contact about my Pet or service animal 7

Home groceries / meal prep ... 7

Use the space below to provide more information about your disabilities/health conditions

Use 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	**Reactions / Symptoms**
Food*	
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

Address

Phone # Fax #

Name

Address

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:
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:
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:
Specialty:
Phone #:

Name:
Specialty:
Phone #:

Name:
Specialty:
Phone #:

Name:
Specialty:
Phone #:

Name:
Specialty:
Phone #:

Name:
Specialty:
Phone #:

Name:
Specialty:
Phone #:

Name:
Specialty:
Phone #:

Surgical History

(Start with most recent procedure)

Type:
When:

Type:
When:

Type:
When:

Type:
When:

Type:
When:

Type:
When:

Type:
When:

Type:
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).)

UNIVERSITY OF DELAWARE
CENTER FOR DISABILITIES STUDIES

University of Delaware, College of Education and Human Development, 461 Wyoming Road, Newark, DE 19716 · 302-831-6974 · 302-831-4689 TDD · cds.udel.edu

DELAWARE DDC DEVELOPMENTAL DISABILITIES COUNCIL

Developmental Disabilities Council, Margaret M.O'Neill Building, Suite 2, 410 Federal Street, 2nd Floor, Dover, DE 19901 · 302-739-3333 302-739-2015 TDD · ddc.delaware.gov