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
- ☐ Using sign language
- ☐ Pointing to words
- ☐ Using gestures/body
- ☐ Writing or typing
- ☐ Using a device
- ☐ Pointing to pictures

Other ways I communicate:

I understand these languages:

Inside Pages:

Medical Profile

Personal Profile

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:

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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 #:

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Specialty:
Phone #:

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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
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DEVELOPMENTAL DISABILITIES COUNCIL

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