

**Disaster Preparedness for People with Disabilities
Emergency Information List**

Please complete this form and distribute copies to your emergency contact people as well as to each member in your network.

Name: _____

Birth Date
m/d//y: _____ / _____ / _____

Address: _____

Phone: (____) _____ - _____

S.S.N.: _____

Local emergency contact person:

Name: _____

Phone: _____

Network Member's:

Name: _____

Phone: _____

Name: _____

Phone: _____

Name: _____

Phone: _____

Name: _____

Phone: _____

Out-of-town contact & numbers:

Name: _____

Phone: _____

Name: _____

Phone: _____

How best to communicate with me:

Medical Information List

Physician
name: _____

Phone: _____

Address: _____

Hospital affiliation: _____

Address: _____

Type of health
insurance: _____

Policy number: _____

Blood type: _____

Allergies and sensitivities:

Medications and dosages being taken:

Specific medical conditions:

Physical limitations:

Adaptive equipment & vendors' phones:

Communication difficulties:

Cognitive difficulties:

**Disability-Related Supplies and Special
Equipment List:**

***Check items you use, and describe item
type and location.***

- Glasses:
- Eating utensils:
- Grooming utensils:
- Dressing devices:
- Writing devices:
- Hearing device:
- Oxygen:

Flow rate:

- Suction equipment:
- Dialysis equipment:
- Sanitary supplies:
- Urinary supplies:
- Ostomy supplies:
- Wheelchair:

Wheelchair repair kit:

- Motorized:
- Manual:
- Walker:
- Crutches:
- Cane(s):
- Dentures:
- Monitors:
- Other:

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people as well as to each member in your
network.***

Source: *American Red Cross*