Emergency Communication 4 ALL

I can’t speak but I can hear and understand you.

My vital information is on the back on this page.

Ask me questions if you need to, but please wait patiently for my replies.

I will point to where I hurt.

Please contact my family.

My technology needs to be charged.

My name is

I, me, my

Bleed

Infect

Allergy

Disability

Help

Bathroom

WHO

You, yours

Broken

Need/Want

Blanket

Disaster

Home

Walker

WHERE

She, her, hers

Burn

Rescue

Clothes

Emergency

Hospital

Wheelchair

WHAT

He, his, him

Choke

Spell

Cold

Family

Sick

Wind

WHEN

They, them, their

Communicate

Talk

Damage

Fire

Pets

Worried

WHY

We, ours

Evacuate

Understand

Danger

Flood

Shelter

Worse/Worst

HOW

YES

Hurt/Injure

Wait

Communication Device

Heat/Hot

Seizure

NO

FREE SPACE (for your custom message)

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PERSONAL INFORMATION

1. NAME _______________________________________
   DOB _________________________________________
   Address ______________________________________
   Cell Phone ____________________
   Home Phone ____________________
   Email ____________________________

2. EMERGENCY CONTACT
   Name _______________________________________
   Address ______________________________________
   Cell Phone ____________________
   Home Phone ____________________
   Relation _________________________

3. 2ND EMERGENCY CONTACT
   Name _______________________________________
   Address ______________________________________
   Cell Phone ____________________
   Home Phone ____________________
   Relation _________________________

4. DOCTOR
   Name _______________________________________
   Address ______________________________________
   Phone ________________________________

5. HEALTH INSURANCE
   ❑ Private ❑ Medicare ❑ Medicaid ❑ Other _________
   Policy Number __________________________
   Date Issued ____________________________

6. PRESCRIPTION MEDICATIONS
   Name & Dosage _____________________________
   Name & Dosage _____________________________
   Name & Dosage _____________________________
   Name & Dosage _____________________________
   Name & Dosage _____________________________

7. OVER THE COUNTER DRUGS
   1) ________________________________
   2) ________________________________

8. PHARMACY NAME _________________________
   Contact Person _________________________
   Phone ________________________________

9. ALLERGIES [complete list] ________________

10. RELEVANT MEDICAL HISTORY [brief] __________

11. SUPPORT AGENCY [if applicable] _____________

12. MEDICAL EQUIPMENT/TECHNOLOGY SUPPLIER ________________

13. EQUIPMENT/SUPPORT NEEDED FOR INDEPENDENCE
   Personal Assistance Services
   Name ________________________________
   Phone ________________________________
   Allotted Hours ________________________
   Mobility/Transferring ____________________
   Communication _________________________
   Hygiene/Toileting /Vision ____________________
   Telephone Use _________________________
   Finances/Writing _______________________ 
   Cooking ______________________________
   Eating and Diet ________________________
   Transportation ________________________
   Service Animals ________________________

Institute on Disabilities
TEMPLE UNIVERSITY
College of Education