Emergency Communication 4 ALL .......................... Letter/Word Communication Aid

FREE SPACE (for your custom message)

MY NAME IS...

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

I will point to where I hurt.

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

My vital information is on the back of this page.

My technology needs to be charged.

Please contact my family.

Oops!

Help

Bathroom

Hungry

Afraid

Sick

I need/want

I can't

0  1  2  3

4  5  6  7

YES  8  9  NO

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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 _______________________________

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