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 vital information is on the back on this page.

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

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)

Emergency Communication 4 ALL ........................................... Picture Communication Aid

© 1981-2009 DynaVox Mayer-Johnson LLC. Used with permission. All rights reserved worldwide.
### 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**

<table>
<thead>
<tr>
<th>Name &amp; Dosage</th>
<th>________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>--------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------</td>
</tr>
</tbody>
</table>

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**