

Emergency Plan

Profile

Name: _____

Address: _____

Date of Birth: _____ SSN: _____

Primary Diagnosis: _____

Secondary Diagnoses: _____

Legal Guardian (attach paperwork if over 18): _____

Phone: _____

Known Allergies: _____

Communication (circle all that apply):

Verbal Sign Language Communication Device Written/Typed

Other: _____

Sensory Needs: _____

Likes & Dislikes: _____

Calming Strategies/De-escalation Techniques: _____

Emergency Plan

Medical information

Primary Insurance: _____

Member Name: _____

Member ID: _____ Enrollment Code: _____

Secondary Insurance: _____

Member Name: _____

Member ID: _____ Enrollment Code: _____

Medicaid MCO: _____

Medicaid #: _____

Additional Supports

Psychiatrist: _____

Phone: _____ On-Call Phone: _____

Case Manager: _____

Phone: _____ On-Call Phone: _____

Residential Provider: _____

Phone: _____ On-Call Phone: _____

Current List of Medications

Name of Medication	Dosage	Time of Day Taken	Reason taken