Emergency Communication 4 ALL  Picture Communication Aid

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

My technology needs to be charged.

My vital information is on the back on this page.

Please contact my family.

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

I will point to where I hurt.

My name is

Who

Where

What

When

Why

How

Yes

No

FREE SPACE (for your custom message)

I will point to where I hurt.

Emergency

Communicate

Damage

Communication Device

Hurt/Injure

Wait

Help

Bleed

Infect

Allergy

Disability

Blanket

Need/Want

Disaster

Home

Walker

Bathroom

Clothes

Emergency

Hospital

Wheelchair

Lid

Wound/Sores

Disability

Yes

No

Communication Device

Heat/Hot

Seizure

Communication Device

Heat/Hot

Seizure

Emergency

Evacuate

Hurt/Injure

Wheelchair

Communication Device

Heat/Hot

Seizure

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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
<table>
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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