DISASTER RELIEF INFORMATION

Name: _____

Address: _____

Phone #: _____

Person(s) to contact in case of emergency: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Doctor's Name: _____ Phone #: _____

Medication(s):

Name: _____

How often is/are your medication(s) taken?: _____

Name: _____

How often is/are your medication(s) taken?: _____

Name: _____

How often is/are your medication(s) taken?: _____

Name: _____

How often is/are your medication(s) taken?: _____

Medical History:

Are you on Oxygen? Yes ☐ No ☐ Are you on Dialysis? Yes ☐ No ☐

Do you require a wheelchair, walker or a cane? Yes ☐ No ☐

If so, which one? _____

Do you need a baby monitor? Yes ☐ No ☐

Do you have any other special needs? _____