The FAMILY EMERGENCY PLAN

Last Updated
_____, 20___

1.0 About the Plan

The family emergency plan has been developed to help our family prepare for and remain calm during an emergency or disaster. This plan should be reviewed by our family 2 times each year. During the review time, our family will make adjustments to this plan as our circumstances change with our family growing older.

As part of each emergency plan review, we will also implement situational drills that will include demonstration and hands-on activities. During an emergency or disaster, this plan may serve as a reference on how to deal with shutting off water, electricity, and natural gas into the home, but it is desirable to learn these tasks during the drills.

Our family emergency plan also includes a communication plan. Each family member will have a wallet-sized copy of our contact information. Mom and Dad will carry it with them in their wallet or purse. Kids will carry the contact information in their backpacks that they use for school.

Each family member will rely on this plan to ensure our safety during an emergency or disaster. This document will change. We expect it to change. Each family member can request the family to adjust the plan to deal with a concern they see that we have not addressed or addressed inadequately.

2.0 The Plan

2.1 The Disaster

2.2 What if I'm in school?

2.3 Who's in charge?

2.4 Likely Disasters and our response.

The most common disasters or emergencies that could occur in our area are:

1) Wild Fire:

2) Earthquake:

3) Snow Blizzard

4) Others:

3.0 The Communication Plan

In a disaster or emergency situation, each family member should attempt to establish communication to HOME. In a disaster or emergency situation, each family group that is together should try to establish contact with our 'Out-of-State' contact. Local phone lines may not be working, but it's common to be able to complete 'Out-of-State' calls. If children are home alone, you should also make contact with next-door neighbors to let them know that you are alone.

3.1 The Wallet Card

Each family member will carry a duplicate of the Family Preparedness Wallet Card. A copy of this sheet can be found in the appendix of this document. The card will include the following information:

- The name of each family member
- The daytime phone number that each family member can be reached at
- Our home address, phone number, email address
- Our 'Out-of-State' family emergency contact
- Our alternate family gathering spot.

3.2 Our Family Contact List

This document includes the name, address, and phone numbers of all our close relatives. A copy of this list can be found in the appendix of this document.

In the event that our family becomes separated, we can use this list along with our primary 'Out-of-State' contact to ensure that we can be reunited. Please understand that our first attempt should be to contact our primary 'Out-of-State' contact. If you are unable to establish that contact, attempt to make contact with others on the list. Let them know who the primary contact is. Have them attempt to make that contact for you.

Our family 'Out-of-State' contact is:

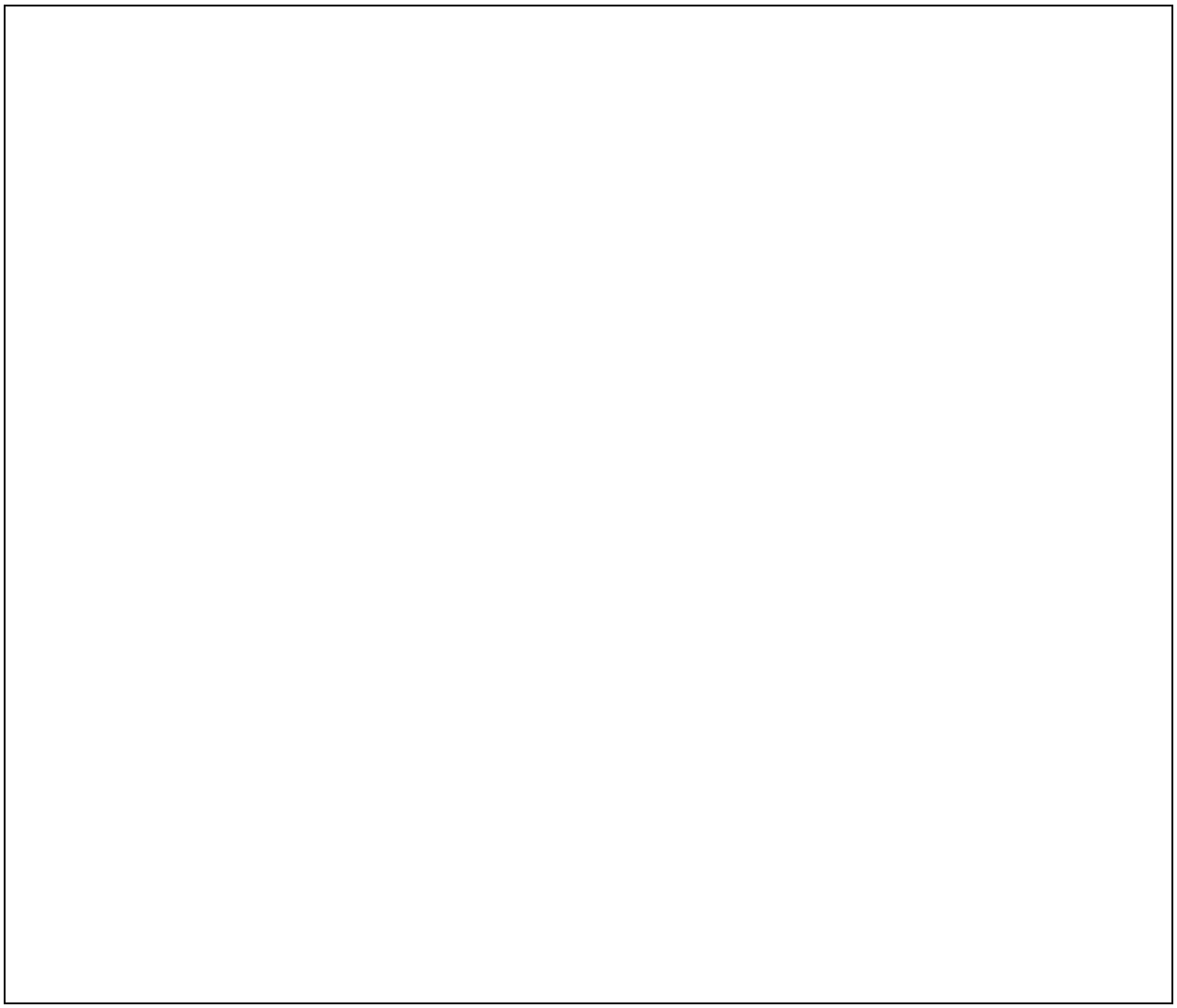
_____

_____

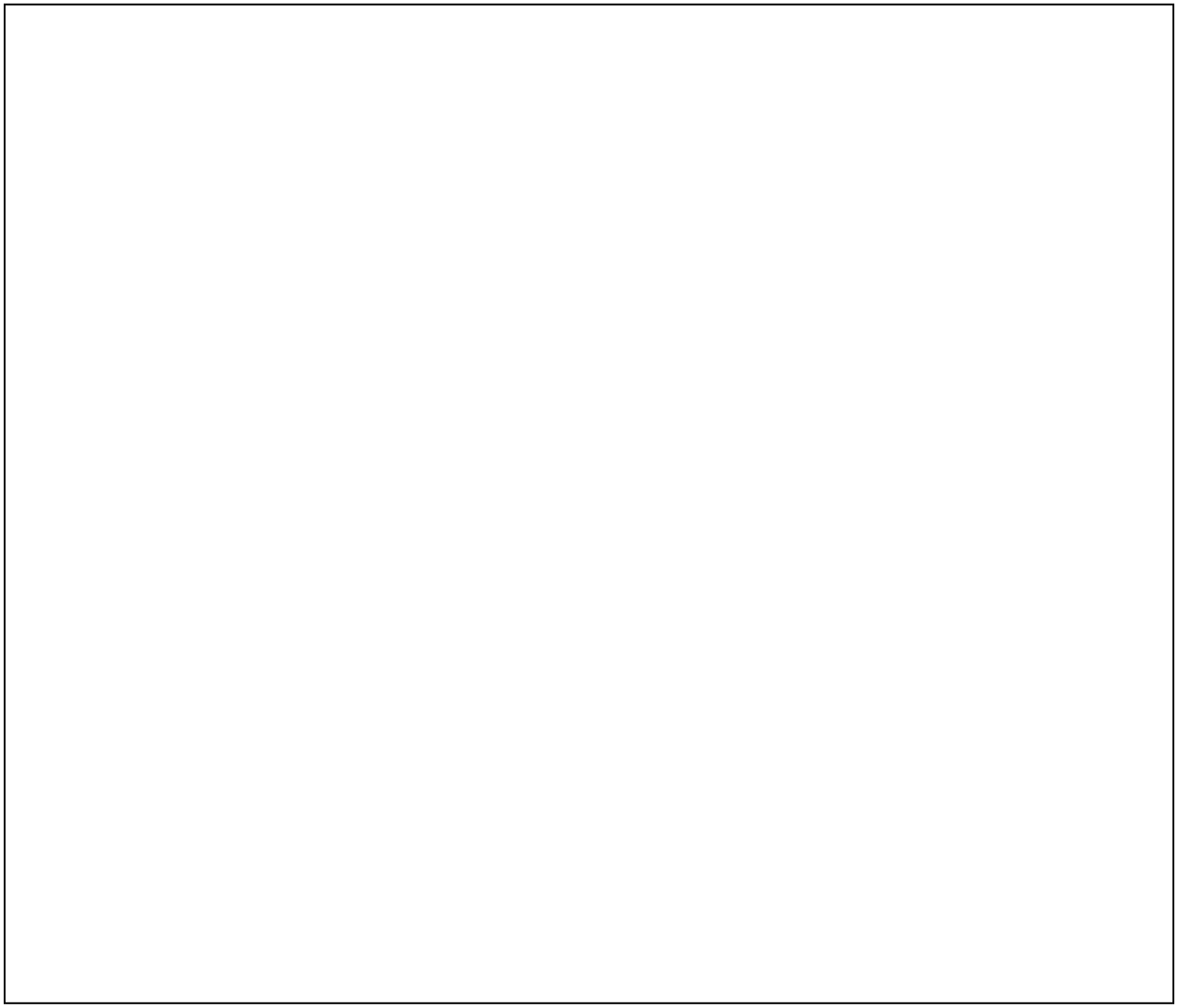
_____

4.0 How Do I ? Checklists

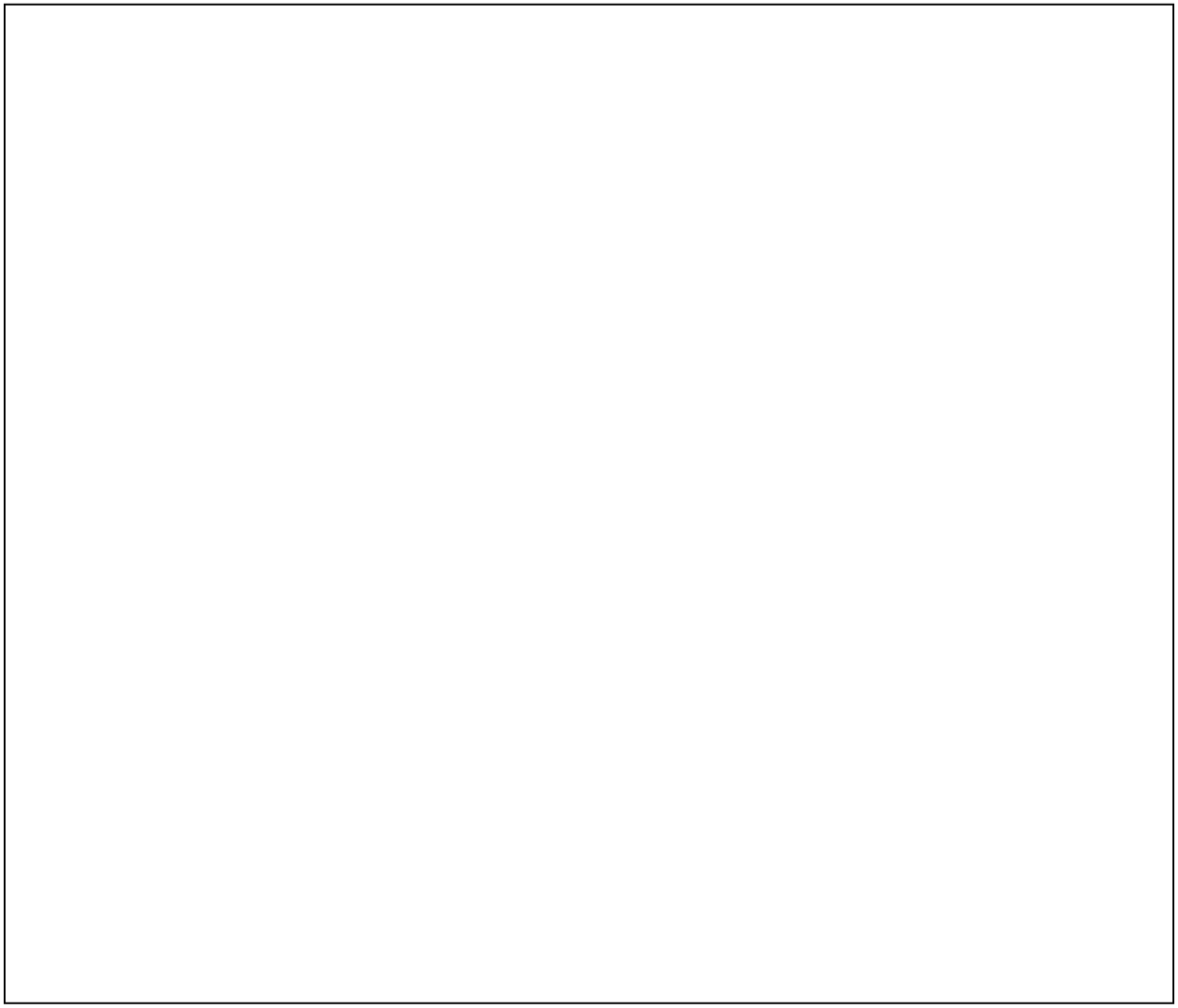
4.1 How do I shut off the water to the home?



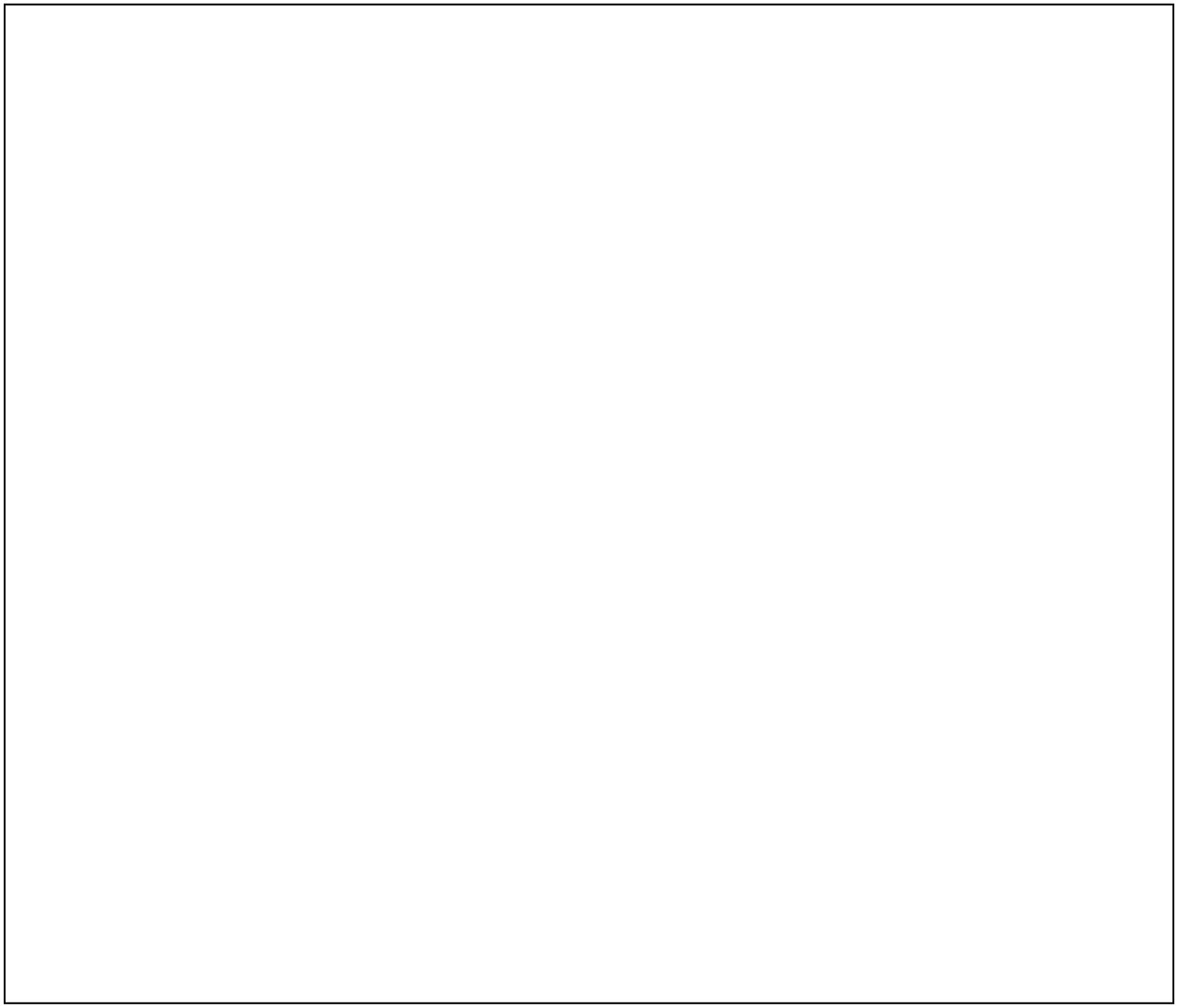
4.2 How do I shut off the power to the home?



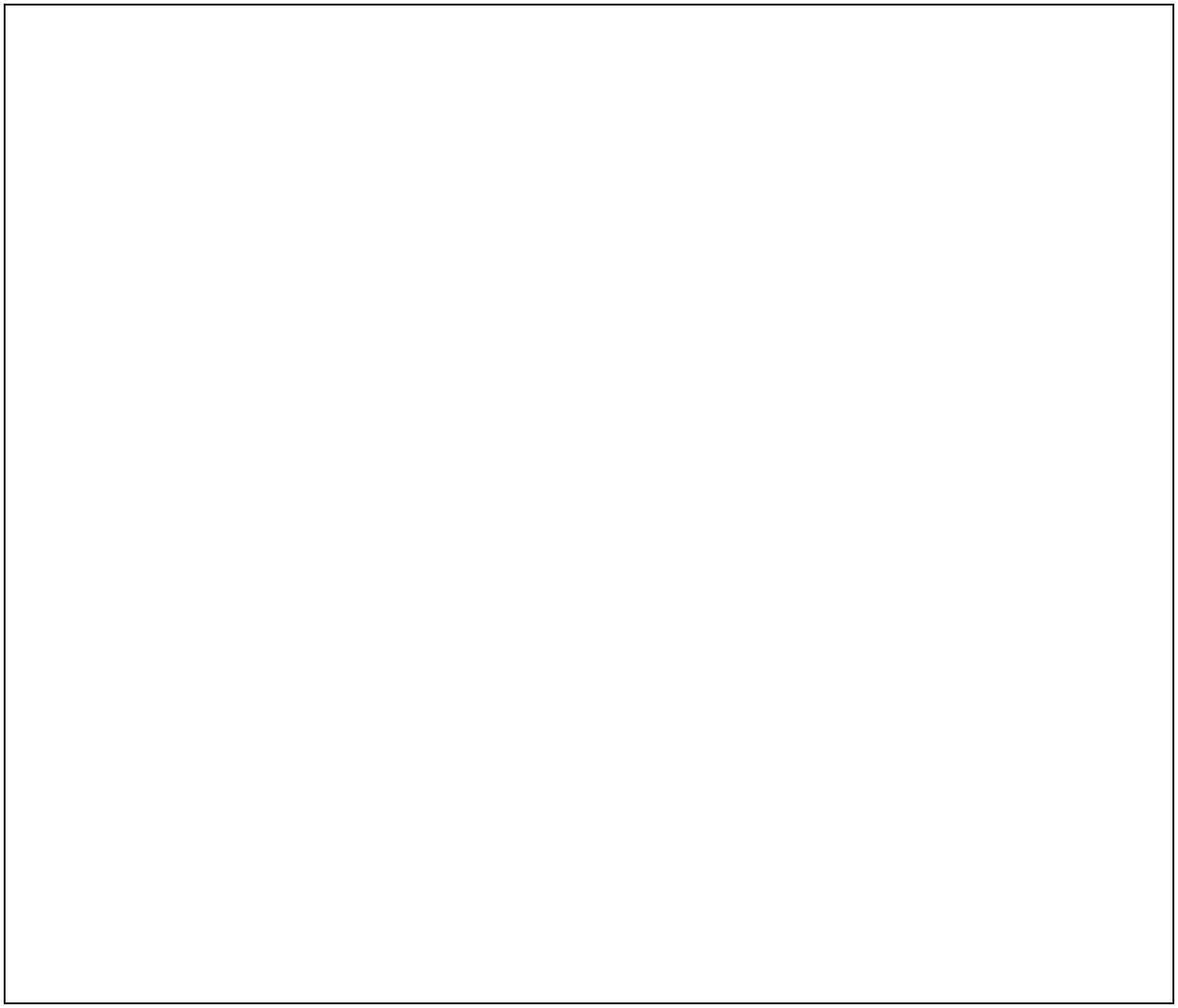
4.3 How do I shut off the natural gas to the home?



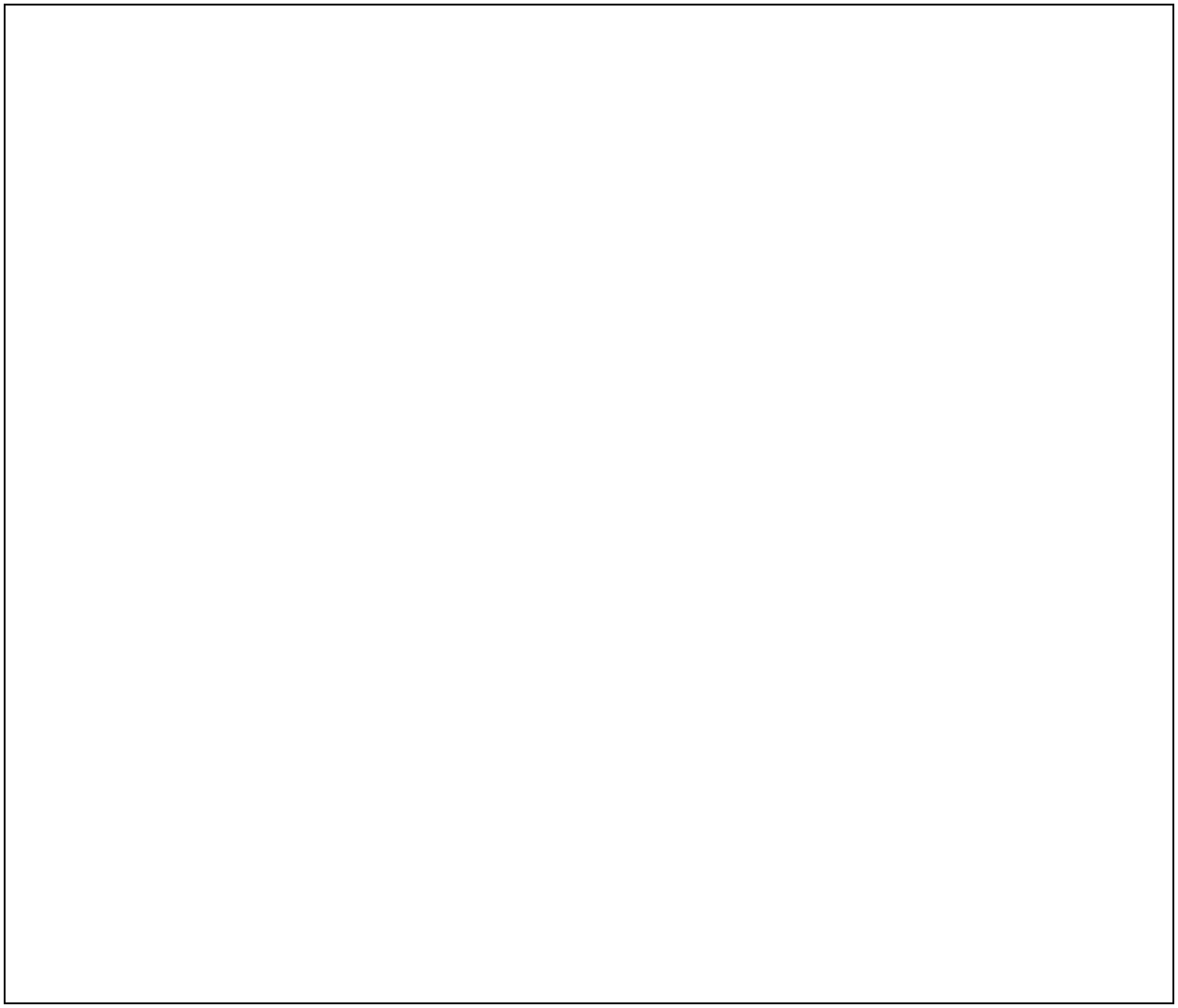
4.4 Where do I find our family fire extinguishers?



4.5 Where are our first-aid kits?



4.6 Where are our 72-hour kits?



4.7 Special Needs / Considerations

5.0 Appendix

Family Emergency Plan

Make sure your family has a plan in case of an emergency. Before an emergency happens, sit down together and decide how you will get in contact with each other, where you will go and what you will do in an emergency. Keep a copy of this plan in your emergency supply kit or another safe place where you can access it in the event of a disaster.

Neighborhood Meeting Place: Phone:

Out-of-Neighborhood Meeting Place: Phone:

Out-of-Town Meeting Place: Phone:

Fill out the following information for each family member and keep it up to date.

Name: Social Security Number:
Date of Birth: Important Medical Information:

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Write down where your family spends the most time: work, school and other places you frequent. Schools, daycare providers, workplaces and apartment buildings should all have site-specific emergency plans that you and your family need to know about.

Work Location One
Address:
Phone:
Evacuation Location:

Work Location Two
Address:
Phone:
Evacuation Location:

Work Location Three
Address:
Phone:
Evacuation Location:

Other place you frequent
Address:
Phone:
Evacuation Location:

School Location One
Address:
Phone:
Evacuation Location:

School Location Two
Address:
Phone:
Evacuation Location:

School Location Three
Address:
Phone:
Evacuation Location:

Other place you frequent
Address:
Phone:
Evacuation Location:

Name	Telephone Number	Policy Number
Police		
Fire		
Hospital		
Animal Control		
Poison Hotline	800-222-1222	

Dial 911 for Emergencies

Family Communication Plan

BeReadyUtah.gov

Be Ready Utah

Make sure your family has a plan in case of an emergency. Fill out these cards and give one to each member of your family to make sure they know who to call and where to meet in case of an emergency.

Additional Important Phone Numbers & Information

Family Communication Plan

Emergency Contact Name:

Telephone:

Out-Of-Town Contact Name:

Telephone:

Neighborhood Meeting Place:

Telephone:

Other Important Information:

DIAL 911 FOR EMERGENCIES

Be Ready Utah

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Additional Important Phone Numbers & Information

Family Communication Plan

Emergency Contact Name:

Telephone:

Out-Of-Town Contact Name:

Telephone:

Neighborhood Meeting Place:

Telephone:

Other Important Information:

DIAL 911 FOR EMERGENCIES

Be Ready Utah

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Additional Important Phone Numbers & Information

Family Communication Plan

Emergency Contact Name:

Telephone:

Out-Of-Town Contact Name:

Telephone:

Neighborhood Meeting Place:

Telephone:

Other Important Information:

DIAL 911 FOR EMERGENCIES

Be Ready Utah

Additional Important Phone Numbers & Information

Family Communication Plan

Emergency Contact Name:

Telephone:

Out-Of-Town Contact Name:

Telephone:

Neighborhood Meeting Place:

Telephone:

Other Important Information:

DIAL 911 FOR EMERGENCIES

Be Ready Utah

To download more of these forms, visit our website www.BeReadyUtah.gov

Harvard Vanguard Medical Associates

Adult Medical History Form

Please complete All **3** PAGES

_____
Name

Your answers on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you**!

PRESENT HEALTH CONCERNS: _____

_____

_____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

Medication	Dose	Times per day

Medication	Dose	Times per day

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:

Medication	Reaction or Side Effect

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis):

____Congenital Heart disease:
specify type
_____
____Myocardial Infarction (Heart attack)
____Hypertension (High blood pressure)
____Diabetes
____High cholesterol____
____Stroke ____
____Thyroid problem
*specify type*_____

____Coagulation (bleeding/clotting) disorder
____Cancer (Malignancy)
*specify type*_____
____Depression/suicide attempt
____Alcoholism
____If you have ever had a blood transfusion, please specify date
_____Abnormal Pap smear

Other problems
_____
_____
_____

When was your last Tetanus shot?
_____

SURGICAL HISTORY (Please list all prior operations and dates)**:**

Operation	Date

Operation	Date

WOMEN'S GYNECOLOGIC HISTORY:

For Women: # pregnancies:____ # deliveries:____ # abortions: ____ # miscarriages: _____
1st day, most recent period: _____ Age at 1st period:____ Frequency of periods:_____ Length of each: _____
Do you have any concerns about your periods? □ No □ Yes: _____
Do you have any concerns about menopause? □ No □ Yes: _____

FAMILY HISTORY:

Please indicate with a check (√) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives
Alcoholism							
Anemia							
Anesthesia problem							
Arthritis							
Asthma							
Birth Defects							
Bleeding problem							
Cancer, Breast							
Cancer, Colon							
Cancer, Melanoma							
Cancer, skin (except melanoma)							
Cancer, Ovary							
Cancer, Prostate							
Cancer (not noted)							
Depression							
Diabetes, Type 1 (childhood onset)							
Diabetes, Type 2 (adult onset)							
Eczema							
Epilepsy(seizures)							

Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives
Genetic diseases							
Glaucoma							
Hay fever (Allergic Rhinitis)							
Hearing problems							
Heart Attack (Coronary Artery Disease)							
High Blood Pressure (Hypertension)							
High cholesterol (Hyperlipidemia)							
Kidney diseases							
Lupus (Systemic Lupus Erythematosis)							
Mental retardation							
Migraine headaches							
Mitral Valve Prolapse							
Osteoarthritis							
Osteoporosis							
Rheumatoid Arthritis							
Stroke							
Thyroid disorders							
Tuberculosis							
Other:							

SOCIAL HISTORY

SUBSTANCES
Tobacco Use
Cigarettes
Quit: Date_____
Never
□ Current: Smoker: packs/day____ # of yrs _____

Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew
Are you interested in quitting? □ No □ Yes

Alcohol Use
Do you drink alcohol? □ No □ Yes: # drinks/week_____
Is alcohol use a concern for you or others? □ No □ Yes

Drug Use
Do you use any recreational drugs? □ No □ Yes
Have you ever used needles? □ No □ Yes

EXERCISE:
Do you exercise regularly? □ No □ Yes

SOCIOECONOMICS:

Occupation: _____

Education completed: □ Grade school □ High school
□ College □ Graduate school
Years of education ____

Marital status: □Single □M □Sep □D □W □Co-habiting
□Engaged…□Other: _____

Spouse/Partner's name: _____
Number of children: _____
Who lives at home with you?_____

SEXUALITY

Sexual Activity

Sexually Active: Yes No Not currently
Current sex partner(s) is/are: male female

Contraception and Protection

Birth Control method:_____ □ None needed
If sexually active, do you practice safe sex? □ NA □ No □ Yes
Have you ever had any sexually transmitted diseases (STDs)?
□ No □ Yes

If yes, please include:
_____date_____
_____date_____

Are you interested in being screened for sexually transmitted diseases? □ No □ Yes

Other concerns?_____
_____

SAFETY:

Do use seatbelts consistently? □ No □ Yes
Do you use a bike helmet regularly? □ NA □ No □ Yes
Is violence at home a concern for you? □ No □ Yes
Do you feel safe in your current relationship? □ NA □ No □ Yes
Do you have a gun in your home? □ No □ Yes

Other concerns?_____
_____

EMOTIONS:

1. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed? □ No □ Yes
2. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes? □ No □ Yes
3. Have you felt depressed or sad much of he time in the past year? □ No □ Yes

IMMUNIZATIONS:

Please list your most recent immunizations. You do NOT need to include any immunizations given at Harvard Vanguard Medical Associates. Please include your best estimate of the month and year of each immunization:

Hepatitis A ____
Hepatitis B ____
Tetanus (Td) ____
Measles ____Mumps____Rubella____
MMR____
Varicella (chicken pox) shot ____
Pneumovax (Pneumonia)____
Other ____

REVIEW OF SYSTEMS: Please check (√) any current problems you have on the list below.

Constitutional
___Fevers/chills/sweats
___Unexplained weight loss/gain
___Fatigue/weakness
___Excessive thirst or urination
Eyes
___Change in vision
Ears/Nose/Throat/Mouth
___Difficult hearing/ringing in ears
___Problems with teeth/gums
___Hay fever/allergies
Cardiovascular
___Chest pain/discomfort
___Leg pain with exercise
___Palpitations
Chest (breast)
___Breast lump/discharge
Respiratory
___Cough/wheeze
___Difficulty breathing
Gastrointestinal
___Abdominal pain
___Blood in bowel movement
___Nausea/vomiting/diarrhea
Genitourinary
___Nighttime urination
___Leaking urine
___Unusual vaginal bleeding
___Discharge: penis or vagina
___Sexual function problems
Musculo-skeletal
___Muscle/joint pain
Skin
___ Rash or mole change
Neurological
___Headaches
___Dizziness/light-headedness
___Numbness
___Memory loss
___Loss of coordination
Psychiatric
___Anxiety/stress
___Problems with sleep
___Depression
Blood/Lymphatic
___Unexplained lumps
___Easy bruising/bleeding
*Other (please specify)*_____
_____