

Emergency Contacts



Urgent Phone Numbers



Call 9-1-1 for Emergency*

Residence Hall Emergency # _____

Residence Hall Director # _____

Residence Advisor (RA) # _____

Campus Police _____

Fire _____

Ambulance _____

Poison Controll _____

Hospital Emergency Room _____

Doctor # 1 _____

Family/Roommate Emergency Contacts

Name	Relationship	Telephone Number(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*** NOTE:** After a large emergency or disaster, the 9-1-1 system may be overwhelmed by callers. Call 9-1-1 only to report an emergency.

Household/Family Member Information

Instructions: Fill in each section for each family member or person living with you.

Your Household Address:

Example

Household/Family Members

Name: Tim Jones		Male/Female M
Relation: Husband	Birth date:	Age:
Health Condition or Special Need: Diabetes		
Home #: 541-123-4567	Cell: 541-456-7890	Work: 541-789-0123
Email Address: timjones@emailaddress.com		
Name:		Male/Female
Relation:	Birth date:	Age:
Health Condition or Special Need:		
Home #:	Cell:	Work:
Email Address:		
Name:		Male/Female
Relation:	Birth date:	Age:
Health Condition or Special Need:		
Home #:	Cell:	Work:
Email Address:		

Household/Family Members

Name:	Male/Female	
Relation:		
Birth date:	Age:	
Health Condition or Special Need:		
Home Phone:	Cell:	Work:
Email Address:		
Name:	Male/Female	
Relation:		
Birth date:	Age:	
Health Condition or Special Need:		
Home Phone:	Cell:	Work:
Email Address:		
Name:	Male/Female	
Relation:		
Birth date:	Age:	
Health Condition or Special Need:		
Home Phone:	Cell:	Work:
Email Address:		
Name:	Male/Female	
Relation:		
Birth date:	Age:	
Health Condition or Special Need:		
Home Phone:	Cell:	Work:
Email Address:		

Non-Household Family, Friends, and Neighbors Information

Instructions: For each section fill in the information for people who do not live with you such as family, friends, and neighbors in the area to call in case of emergency.

Non-Household Family, Friends and Neighbors Information

Name:		Male/Female
Relationship:		
Birth date:		Age:
Home Phone:	Cell:	Work:
Email Address:		
Name:		Male/Female
Relationship:		
Birth date:		Age:
Home Phone:	Cell:	Work:
Email Address:		
Name:		Male/Female
Relationship:		
Birth date:		Age:
Home Phone:	Cell:	Work:
Email Address:		
Name:		Male/Female
Relationship:		
Birth date:		Age:
Home Phone:	Cell:	Work:
Email Address:		

People I can check in on ...

If you are able to check in on some other people who may be more vulnerable or need extra help in an emergency or disaster, add them to your list below. These may be elderly, disabled or people with special needs, those who are sick, single parents, people with limited English skills, to name a few. **You can be a lifeline in an emergency and a friendly voice in a scary situation.**

Name:	Male/Female	Approximate Age:
Relationship:		
Address:		
Home Phone:	Cell:	Work:
Email Address:		
Other Information:		
Name:	Male/Female	Approximate Age:
Relationship:		
Address:		
Home Phone:	Cell:	Work:
Email Address:		
Other Information:		
Name:	Male/Female	Approximate Age:
Relationship:		
Address:		
Home Phone:	Cell:	Work:
Email Address:		
Other Information:		

Out of Area Contacts

Instructions: Fill in each section for each out-of-area contact. Make sure each out-of-area contact lives at least 100 miles away from you.

Name:	Male/Female	Approximate Age:
Relationship:		
Address:		
Home Phone:	Cell:	Work:
Email Address:		
Name:	Male/Female	Approximate Age:
Relationship:		
Address:		
Home Phone:	Cell:	Work:
Email Address:		
Other Information:		
Name:	Male/Female	Approximate Age:
Relationship:		
Address:		
Home Phone:	Cell:	Work:
Email Address:		
Other Information:		
Name:	Male/Female	Approximate Age:
Relationship:		
Address:		
Home Phone:	Cell:	Work:
Email Address:		
Other Information:		

Pets

Instructions: Complete for each household pet.

Pet Name:	Description:
Pet License #:	Male Female Neutered (circle all that apply)
Shots and Dates:	
Medications and special needs:	
Vet Name:	Vet Phone#:
Pet Name:	Description:
Pet License #:	Male Female Neutered (circle all that apply)
Shots and Dates:	
Medications and special needs:	
Vet Name:	Vet Phone#:
Pet Name:	Description:
Pet License #:	Male Female Neutered (circle all that apply)
Shots and Dates:	
Medications and special needs:	
Vet Name:	Vet Phone#:

Vehicle Information

Vehicle Make:	Model:
Year:	License#:
	Color:
Vehicle Make:	Model:
Year:	License#:
	Color:
Vehicle Make:	Model:
Year:	License#:
	Color:

Emergency Procedures for Work, School, and Other Important Places

Instructions: For each family member, fill in each section with work or school information and instructions on what to do during an emergency.

Family Member

Family Member: Tim Jones	Male/Female: M	Approximate Age: 45
Place: Work – Bob’s Tires	Example	
Address: 1122 NW Spring Street, Corvallis		
Phone: 754-9999		
Emergency Procedures: Store will close down. Workers will gather in parking place.		
Family Member:	Male/Female:	Approximate Age:
Place:		
Address:		
Phone:		
Emergency Procedures:		
Family Member:	Male/Female:	Approximate Age:
Place:		
Address:		
Phone:		
Emergency Procedures:		
Family Member:	Male/Female:	Approximate Age:
Place:		
Address:		
Phone:		
Emergency Procedures:		

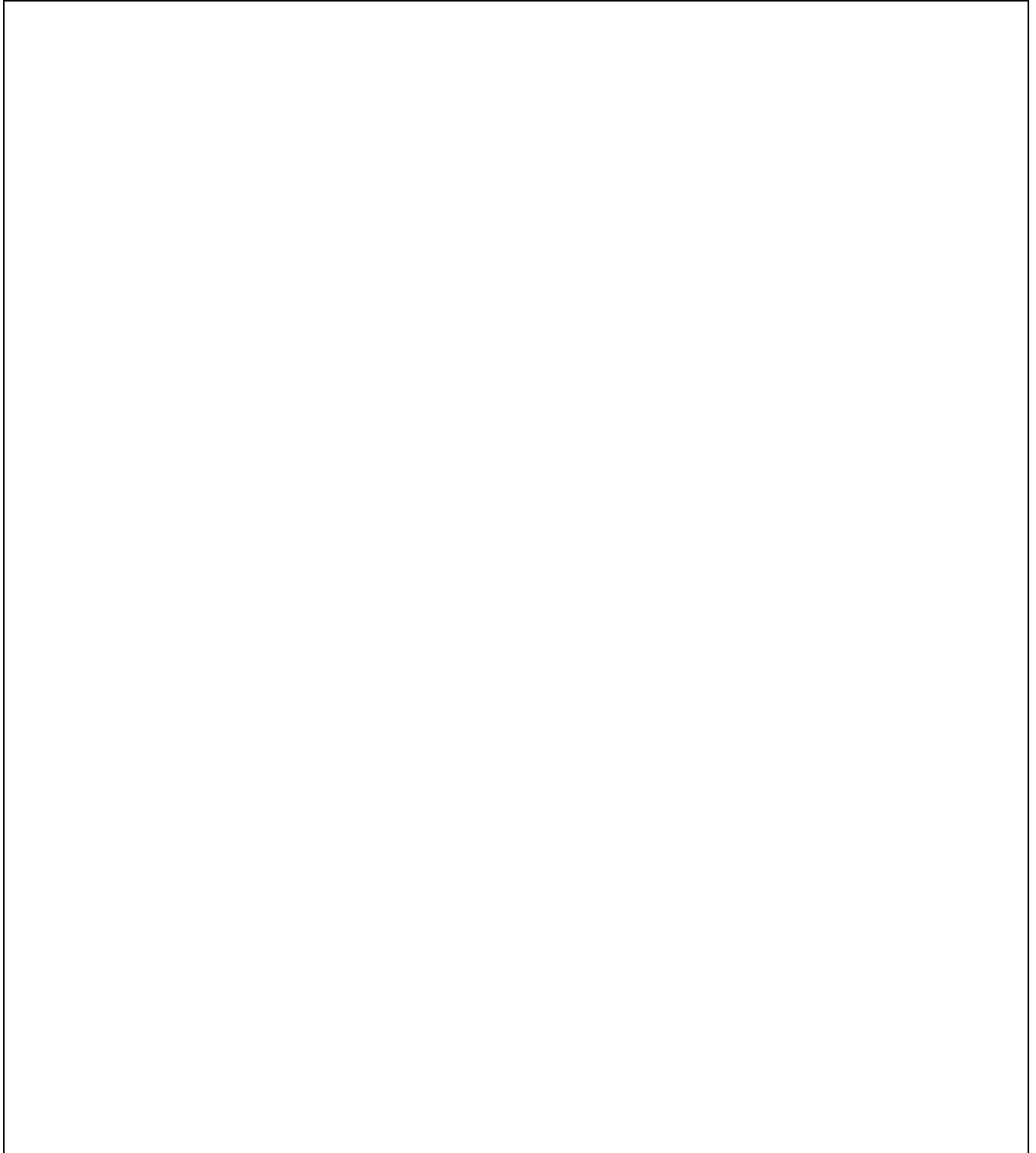
Family Meeting Places

Instructions: For each location, decide where to meet. Then right down what to do when you arrive at the meeting place or what to do if you cannot get to the meeting place.

In or Around Home:	Place to meet inside of home:
	Procedure:
	Place to meet outside of home:
	Procedure:
In the Neighborhood:	Place to meet in the neighborhood:
	Procedure:
In the Community:	Place to meet in the community:
	Procedure:

Home Layout

Instructions: Sketch the layout of your home. Include important places and information like utility shutoffs, safety equipment (fire extinguishers), emergency supply kits, and meeting places in the drawing.

A large, empty rectangular box with a thin black border, intended for a hand-drawn sketch of a home layout. The box occupies the majority of the page below the instructions.

Medical Provider Contact Information

Instructions: For each household or family member, fill in information for each type of provider, for example a doctor, dentist, pharmacist, specialist, or eye doctor.

Medical Provider Contact Information

Type of Provider: Pharmacist	
Provider Name: John Doe	Example
Provider Location: ABC Pharmacy	
Provider Address: 123 Medicine St., Corvallis, OR 97330	
Provider Phone #: (541) 123-4567	
Patient Name: Tim Jones	
Type of Provider:	
Provider Name:	
Provider Location:	
Provider Address:	
Provider Phone #:	
Patient Name:	
Type of Provider:	
Provider Name:	
Provider Location:	
Provider Address:	
Provider Phone #:	
Patient Name:	
Type of Provider:	
Provider Name:	
Provider Location:	
Provider Address:	
Provider Phone #:	
Patient Name:	

Medical Provider Contact Information

Type of Provider:
Provider Name:
Provider Location:
Provider Address:
Provider Phone #:
Patient Name:
Type of Provider:
Provider Name:
Provider Location:
Provider Address:
Provider Phone #:
Patient Name:
Type of Provider:
Provider Name:
Provider Location:
Provider Address:
Provider Phone #:
Patient Name:
Type of Provider:
Provider Name:
Provider Location:
Provider Address:
Provider Phone #:
Patient Name:

Medication List

Instructions: For each household/family member, fill in each section with medication and medical information.



Medications

Patient Name:	Male/Female:	Approximate Age:
Medication Name:		
Medication Instructions		
Reason for Taking:		
Date Started:		
Where Medicine is Kept:		
Doctor Name:		
Doctor Phone Number:		
Patient Name:	Male/Female:	Approximate Age:
Medication Name:		
Medication Instructions		
Reason for Taking:		
Date Started:		
Where Medicine is Kept:		
Doctor Name:		
Doctor Phone Number:		
Patient Name:	Male/Female:	Approximate Age:
Medication Name:		
Medication Instructions		
Reason for Taking:		
Date Started:		
Where Medicine is Kept:		
Doctor Name:		
Doctor Phone Number:		

Medications

Patient Name:	Male/Female:	Approximate Age:
Medication Name:		
Medication Instructions		
Reason for Taking:		
Date Started:		
Where Medicine is Kept:		
Doctor Name:		
Doctor Phone Number:		
Patient Name:	Male/Female:	Approximate Age:
Medication Name:		
Medication Instructions		
Reason for Taking:		
Date Started:		
Where Medicine is Kept:		
Doctor Name:		
Doctor Phone Number:		
Patient Name:	Male/Female:	Approximate Age:
Medication Name:		
Medication Instructions		
Reason for Taking:		
Date Started:		
Where Medicine is Kept:		
Doctor Name:		
Doctor Phone Number:		

Date of last update of Medications pages:			
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Allergy and Other Health Information

Instructions: For each household/family member, list all allergies and important health information.

Example

Patient Name: Allen Jones	Male/Female: M	Approximate Age: 70
Names of Medicines Allergic to: Penicillin	Example	
Other Allergies to: Cats, Milk Products		
Other Health Information: Insulin dependent diabetic, uses a walker, hard of hearing		
Patient Name:	Male/Female:	Approximate Age:
Names of Medicines Allergic to:		
Other Allergies to:		
Other Health Information:		
Patient Name:	Male/Female:	Approximate Age:
Names of Medicines Allergic to:		
Other Allergies to:		
Other Health Information:		
Patient Name:	Male/Female:	Approximate Age:
Names of Medicines Allergic to:		
Other Allergies to:		
Other Health Information:		
Patient Name:	Male/Female:	Approximate Age:
Names of Medicines Allergic to:		
Other Allergies to:		
Other Health Information:		



Allergy and Other Health Information

Patient Name:	Male/Female:	Approximate Age:
Names of Medicines Allergic to:		
Other Allergies to:		
Other Health Information:		



Patient Name:	Male/Female:	Approximate Age:
Names of Medicines Allergic to:		
Other Allergies to:		
Other Health Information:		



Patient Name:	Male/Female:	Approximate Age:
Names of Medicines Allergic to:		
Other Allergies to:		
Other Health Information:		



Patient Name:	Male/Female:	Approximate Age:
Names of Medicines Allergic to:		
Other Allergies to:		
Other Health Information:		




Utility and Service Contacts:



Instructions: Fill in each section for each type of service.

Type of Service: Water/Sewer
Service Provider:
Account Number:
Local Address:
Phone:

Type of Service: Electricity
Service Provider:
Account Number:
Local Address:
Phone:



If your power is out, switch your front porch light on so that officials can see when your service is back on.

Type of Service: Gas / Oil / Propane (circle one)
Service Provider:
Account Number:
Local Address:
Phone:

Type of Service: Garbage
Service Provider: Pick-up Day:
Account Number:
Local Address:
Phone:

Utility and Service Contracts

Type of Service: Cable
Service Provider:
Account Number:
Local Address:
Phone:
Type of Service: Telephone
Service Provider:
Account Number:
Local Address:
Phone:
Type of Service: Cell Phone
Service Provider:
Account Number:
Local Address:
Phone:
Type of Service: Well/Septic
Service Provider:
Account Number:
Local Address:
Phone:

Insurance and Other Important Information

Instructions: Fill in each section for each type of insurance provider (i.e. health insurance, vehicle insurance, life insurance)

Example

Information Name: State Farm	Example
Policy or other numbers: HJ 987655434	
Local Address: 999 South Street, Albany	
Phone: 967-0000	
Notes: car insurance, homeowners insurance, life insurance policies.	
Information Name:	
Policy or other numbers:	
Local Address:	
Phone:	
Notes:	
Information Name:	
Policy or other numbers:	
Local Address:	
Phone:	
Notes:	
Information Name:	
Policy or other numbers:	
Local Address:	
Phone:	
Notes:	

Important Notes:

If a note refers to information on a specific page of this booklet, include the page number.