

# Emergency Communications Plan

Disasters and emergencies are inevitable in today's world

This is a fillable PDF that you can print and put in your Go Bag, and/or download to your device.



dem.nv.gov

## My Information

My name

First

Last

Street Address

Address Line 2

City

ZIP Code

My phone number

My email address

## My Emergency Contact

Emergency contact name First

Last

Emergency contact phone number

Emergency contact email address

## Family Members

Family Member 1:  
Name

Phone

Email

Other Contact

Other  
info

Family Member 2:  
Name

Phone

Email

Other Contact

Other  
info

## Emergency Plans

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Enter information for schools, childcare, caregivers and workplaces

Name:

Name:

Address:

Address:

Emergency Hotline:

Emergency Hotline:

Website:

Website:

Emergency Plan/Pick-up

Emergency Plan/Pick-up

## Emergency Meeting Places

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Location:

Instructions:

## Medical Information

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Poison Control: 1-800-222-1222

Pediatrician Name:

Doctor's Name:

Pediatrician #:

Doctor's #:

Allergy information  
and prescriptions:

Medical Insurance Name:

Medical Insurance Policy #:

Additional Information:

## My Household

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### Will anyone be traveling with you?

You may or may not live with other people, like family members, roommates, or a caretaker. If you do live with other people, will they be traveling with you during an emergency?

Yes

No

## My Pets

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### Do you have a pet?

Do you have a pet, service animal, and/or emotional support animal that will travel with you during an emergency?

Yes      No

Veterinarian Name:

Veterinarian #:

Pet Medications:

Microchipped?    Yes      No

Pet Breed:

Pet Vaccinations:

Additional Information:

## My Health or Functional Needs

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My doctor's name:

My doctor's phone number:

### My health conditions

List any disabilities or known health conditions you may be experiencing.

### My medications

List your medications, including dosage and frequency, also including those only taken as-needed. Please list each medication on a separate line.

### My allergies

List the things you're allergic to.

**My Durable Medical Equipment or Assistive Technology/AT devices**

List any Durable Medical Equipment (DME) or Assistive Technology (AT) you use. If possible, please include the serial number of the device.

**My support services**

For example, some people have attendant services for nursing, daily living, or mental health.

## Communication & Religion

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**What is the best way to communicate with you?**

For example, some people communicate via American Sign Language (ASL), some people use an assistive device, some people prefer to not make eye contact, etc.

**Preferred language**

For example, some people prefer to speak English or Spanish, use ASL, etc.

**Religious considerations**

If you would like to have your religion taken into account during an emergency, please provide information about your religious preferences.

**My local radio station**

# My Local Disaster or Emergency Contacts

These could include contacts from your county and/or your city.

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Office of Emergency Management phone number

Fire Department phone number

Sheriff or Police Department phone number

Public transportation or paratransit phone number

## My Utility Providers

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Electric company name

Electric company phone number

Are you a critical care customer with your electric company?

Yes

No

I'm not sure

Gas company name

Gas company phone number

Are you a critical care customer with your gas company?

Yes

No

I don't know

Water company name

Water company phone number

# Healthcare, Durable Medical Equipment & Assistive Technology Providers

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Healthcare agency name

Healthcare agency phone number

**Emergency healthcare plan**

How do you plan to access healthcare if there is an emergency?

**Durable Medical Equipment provider name**

What is the name of the company or agency that provides your Durable Medical Equipment (DME)?

**Durable Medical Equipment provider phone number**

**Emergency Durable Medical Equipment plan**

How do you plan to access DME if there is an emergency?

**Assistive Technology provider name**

What is the name of the company or agency that provides your Assistive Technology (AT)?

**Assistive Technology provider phone number**

**Emergency Assistive Technology plan**

How do you plan to access Assistive Technology if there is an emergency?

## My Transportation

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**Emergency transportation plan**

If you need to leave your home during an emergency, do you have your own transportation?

Yes, I have my own transportation

No, I don't have my own transportation