My Personal Emergency Plan

____________________________________________________
Name of Student

IRAA SEP

Personal Emergency Plan (PEP)

Today’s Date: ________________

Completed By: ________________
In an emergency, people help each other. List some ways that you might be able to help others, and some ways that you might need some help.

I can help by: _____________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

➔ Insert photo chosen by student of her/himself and friends/family.

➔ Student may be encouraged to draw a picture of her/himself above as a helper in an emergency.
In an emergency, I may need help with:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Student may be encouraged to draw a picture of her/himself above receiving help in an emergency
PERSONAL INFORMATION

Child’s Name: __________________________________________________________

Nick Name: ____________________________________________________________

Child’s Street Address: ___________________________________________________

City or Town: ___________________________________________________________

Date of Birth: __________ Gender: _________ Height: _________ Weight: __________

Hair Color: _________ Eye Color: _________ Identifying Marks: ___________________

Blood Type: ______________ Allergies: _____________________________________

Primary spoken/understood language: _______________________________________

EMERGENCY CONTACT INFORMATION

Primary Emergency Contact Name: _________________________________________

Parents/Guardian Names: ________________________________________________

Street Address: _________________________________________________________

City or Town: ___________________________________________________________

Please provide contact information and circle the best methods for reaching you:

Home Phone: _______________________ Home Email: ________________________

Work Phone: _______________________ Work Email: _________________________

Mobile Phone: __________________________________________________________

AND
Secondary Emergency Contact Name: ________________________________

Parents/Guardian Names: _________________________________________

Street Address: _________________________________________________

City or Town: ________________________________________________

Please provide contact information and circle the best methods for reaching:

Home Phone: _______________________ Home Email: ________________________

Work Phone: _______________________ Work Email: _________________________

Mobile Phone: ______________________________________________________

OTHER INFORMATION

Please describe any additional information about emergency contacts in the space below including custody or other relevant matters that may enhance communication between _____________________________ and the school. ____________________________

(Insert student’s name)
### SERVICE PROVIDERS

**Pediatrician:**
- (name)  
- (phone)

**Physical Therapist:**
- (name)  
- (phone)

**Occupational Therapist:**
- (name)  
- (phone)

**Psychiatrist:**
- (name)  
- (phone)

**Behavioral Health Counselor:**
- (name)  
- (phone)

**Other Providers (PCA, etc.):**
- (name)  
- (phone)

**Health Insurance Company and Policy Number:**

The most critical information to know about: (Insert student's name) is:

1. 

2. 

3. 

4. 

5.
FUNCTIONAL NEEDS: MEDICAL

Potentially life-threatening conditions: _______________________________________
______________________________________________________________________
______________________________________________________________________

Conditions needing constant attention: _____________________________________
______________________________________________________________________
______________________________________________________________________

Medicines: _____________________________________________________________
______________________________________________________________________
______________________________________________________________________

Life-sustaining medicines: ________________________________________________
______________________________________________________________________
______________________________________________________________________

Medical or adapted equipment (if used, please specify):________________________
______________________________________________________________________
______________________________________________________________________

Planning documents for life-threatening condition(s) are stored and located at:
______________________________________________________________________
FUNCTIONAL NEEDS: CRITICAL ISSUES

Nutrition
What accommodations are required to eat? ____________________________________________
________________________________________________________________________________
Special Diet: _____________________________________________________________________
________________________________________________________________________________

Hygiene
Toileting/Bathing: ________________________________________________________________
________________________________________________________________________________

Sleeping
Lighting: _______________________________________________________________________
________________________________________________________________________________
Sounds: __________________________________________________________________________
________________________________________________________________________________
Other: ___________________________________________________________________________
FUNCTIONAL NEEDS: SUPPORT IN AN EMERGENCY

During a disaster or emergency is likely to need support or help in the following areas:

Communication:

Reading ________ Writing ________ Reasoning ________ Hearing ________

Behavior Management and Mood (please describe): ________________________________

____________________________________________________________________

Hearing and Sight: ______________________________________________________

Mobility, Movement and Physical Stamina: _________________________________

Taking Medicines and Monitoring Medical Conditions: _______________________

____________________________________________________________________

Activities of Daily Living (dressing, grooming, tooth brushing, bathing, toileting, eating, drinking, sleeping): ________________________________

____________________________________________________________________

Service Animal(s) – Type/Function (please attach picture and name of service animal):

____________________________________________________________________

Transportation: _________________________________________________________

Cultural Practices: ______________________________________________________
FUNCTIONAL NEEDS: SUPPORT IN AN EMERGENCY

What strategies, tools, equipment or items bring comfort to ___________________________? Please describe:

(Insert student’s name)

Does s/he have a favorite activity or object? Please describe: __________________________

➔ Insert photo of stuffed animal, toys, objects, etc.

Is there anything else that you want emergency responders and school personnel to know about ___________________________?  

(Insert student’s name)

Please describe:

➔ Optional photo of student and family member here:

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