

FAMILY EMERGENCY PLAN

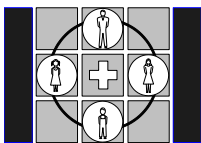
For the family of



*Prepared by: Edward Stone
for*

Sherwood Police Department Emergency Management





Residential

LOCAL INFORMATION



Home Community of:

Home Address

EMERGENCY

POLICE-FIRE-MEDICAL

Dial:

911



Municipal Service Numbers

Non-Emergency
 Fire/EMS Department _____
 WEB Site _____

Non-Emergency
 Police Department _____
 WEB Site _____

Municipal Office _____
 WEB Site _____
 Other _____
 EAS Radio Station(s)

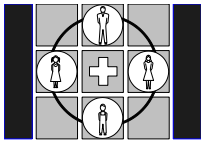
Utility Emergency Numbers
 Gas Provider _____
 Electric Provider _____
 Water Provider _____

Poison Control _____
 American Red Cross _____
 Other _____

Other Local Critical Service Numbers

H **Primary/Closest Hospital**
 Name _____
 Address _____
 Phone _____
Primary Urgent Care
 Name _____
 Address _____
 Phone _____

H **Secondary Hospital**
 Name _____
 Address _____
 Phone _____
Secondary Urgent Care
 Name _____
 Address _____
 Phone _____



Employer

LOCAL INFORMATION



Employer Community of: _____

Employer Name & Address: _____

EMERGENCY

POLICE-FIRE-MEDICAL

Dial:

911



Municipal Service Numbers

Non-Emergency
 Fire/EMS Department _____
 WEB Site _____

Non-Emergency
 Police Department _____
 WEB Site _____

Municipal Office _____
 WEB Site _____
 Other _____
 EAS Radio Station(s) _____

Utility Emergency Numbers
 Gas Provider _____
 Electric Provider _____
 Water Provider _____

Poison Control _____
 American Red Cross _____
 Other _____

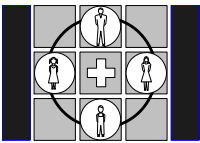
Other Local Critical Service Numbers

H **Primary/Closest Hospital**
 Name _____
 Address _____
 Phone _____

Primary Urgent Care
 Name _____
 Address _____
 Phone _____

H **Secondary Hospital**
 Name _____
 Address _____
 Phone _____

Secondary Urgent Care
 Name _____
 Address _____
 Phone _____



FAMILY COMMUNICATIONS

Primary Family Communications Plan



In the event of an emergency, you may not be able to communicate to your family by the usual methods. Complete the section below and be sure all family members have the information available when needed. Complete and try as many methods as you have available,

Plan A: First method of communication: Call family at home or work. If this fails, go to Plan B.

Plan B: Second method of communication: _____ If this fails, go to Plan C.

Plan C: Third method of communication: _____ If this fails, go to plan D.

Plan D: Go Home or Designated Meeting Places

Other Media Service

_____		<input type="checkbox"/>
_____		<input type="checkbox"/>
_____		<input type="checkbox"/>
_____		<input type="checkbox"/>

Suggested Methods: Telephone, Answering Machine, Cell Phone, Cell-Text Messaging, Pager/Text Pager, E-mail, Calling Card, Third Party Contacts, social media or Posting Paper Messages or two way radio.

Local Family Members

Name _____
 Address _____
 Phone1 _____
 Phone 2 _____
 Other _____

Name _____
 Address _____
 Phone1 _____
 Phone 2 _____
 Other _____

Name _____
 Address _____
 Phone1 _____
 Phone 2 _____
 Other _____

Out of Town Relay Contact Numbers

Name _____ # _____
 Name _____ # _____
 Name _____ # _____

ATTACH A LIST OF ADDITIONAL CONTACTS – PRINT A COPY OF PHONE CONTACTS IN CASE OF PHONE FAILURE

Telephone Call-Out Instructions: _____

If you have an **answering machine** with remote access, complete this section:

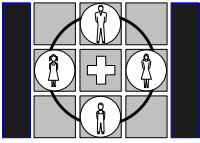
When no one is home, each family member can leave a message with his or her whereabouts and destination. Each family member can retrieve these messages.

Remote Access Instructions: _____

Toll Free Calling Card Instructions: _____

When communicating remember to address any critical needs listed below:

Critical Needs: Medical Power Pharmacy Dietary Transport/Evacuation Needs Other



EVAC/MEETING & SHELTER PLAN

Family Meeting Places:

In the event of an emergency, you may not be able to get home or meet your family in the usual place. Predetermine three places your family can meet if your home is not accessible. The first place should be within walking distance of your home. If that is not accessible, list a second place a few miles from your home. If that is not accessible, list a third (Friend or relative) place 20-50 miles from home. Some meeting places may also be alternate places to stay. If not, list alternate places to stay in section 2.

1. _____ Phone # _____
CLOSE TO HOME

2. _____ Phone # _____
IN THE AREA

3. _____ Phone # _____
OUT OF TOWN

Validated

In a wide area disaster agencies such as the American Red Cross can assist in locating your relatives.

Alternate Places to Stay

1. _____ Phone # _____
CLOSE TO HOME

2. _____ Phone # _____
IN THE AREA

3. _____ Phone # _____
OUT OF TOWN

Validated

Local Public Shelter Information:

Special Support & Instructions

Support Personnel & Transportation Alternatives:

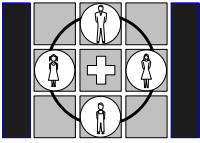
List two parties that can assist you and your family with transportation in the event your own transportation is not available or for children/relatives that do not drive.

Name & Phone Numbers:

Name _____ Home Phone _____ Work Phone _____

Name _____ Home Phone _____ Work Phone _____

Validated



FAMILY EVACUATION CHECKLIST

In home exit plan: Ambulatory Evacuation Assisted Evacuation by _____

Plan: _____
USE THIS SECTION FOR ANY FAMILY MEMBER REQUIRING ADDITIONAL SUPPORT WITH EVACUATION

Validated

Primary Evacuation Checklist:

Create a checklist of items (and locations) needed for an evacuation:

- Medications Location _____
- Go-Kit Location _____
- Special Dietary Snacks Location _____
- _____ Location _____
- _____ Location _____
- _____ Location _____

The list should include items such as medications, special foods, ID documents, insurance papers, and/or deeds.

Things to do to secure your residence when you evacuate:

- Turn off appliances
- Secure doors and windows
- _____
- _____

Final Items:

- Change phone message (or forward your home phone to your cell phone)
- Leave note with your destination, time of departure and method of travel.
- Arrange for pets
- _____
- _____

Utility Shut Down Checklist

Only shut down utilities if instructed to do so or if a dangerous condition exists.

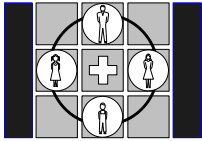
- Gas Main - Location _____
- Electric* Main - Location: _____
- Water Main – Location: _____

*Unplug or switch off breakers for all unnecessary items before departure

Use one of the evacuation guides to review a more in depth guide and evacuation checklist.



Emergency Cash:



HEALTH SUPPORT

Basic Family Member Medication

If you require special medication or food needs that are likely to become unavailable in an emergency, list alternatives or instructions for each applicable family member along with the need. If medications are required, keep a copy of the prescription(s) with this plan for emergency reference.

KEEP IN MIND: ACQUISITION LEAD TIME(S) WILL BE SUBSTANTIALLY LONGER IN TIME OF EMERGENCIES

Family Member	Physician	Source	Online	↓
Medication(s):				
Name _____	Dose _____	Time(s) _____	ALT _____	<input type="checkbox"/>
Name _____	Dose _____	Time(s) _____	ALT _____	<input type="checkbox"/>
Name _____	Dose _____	Time(s) _____	ALT _____	<input type="checkbox"/>
Name _____	Dose _____	Time(s) _____	ALT _____	<input type="checkbox"/>
Name _____	Dose _____	Time(s) _____	ALT _____	<input type="checkbox"/>

ALT = Acquisition Lead Time (Days) ↑

Dietary:

Family Member	Physician	Source	Online	↓
Medication(s):				
Name _____	Dose _____	Time(s) _____	ALT _____	<input type="checkbox"/>
Name _____	Dose _____	Time(s) _____	ALT _____	<input type="checkbox"/>
Name _____	Dose _____	Time(s) _____	ALT _____	<input type="checkbox"/>
Name _____	Dose _____	Time(s) _____	ALT _____	<input type="checkbox"/>
Name _____	Dose _____	Time(s) _____	ALT _____	<input type="checkbox"/>

ALT = Acquisition Lead Time (Days) ↑

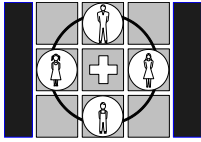
Dietary:

Other Routine & Required Health Maintenance Support Services

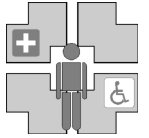
_____ **Delivered by:** _____ **Schedule:** _____

_____ **Delivered by:** _____ **Schedule:** _____

A more detailed medication & testing log form is available from the instructor



HEALTH SUPPORT SUPPLEMENT



Individual Medication Testing & Dietary Schedule

If you require special medication, food or testing needs that are likely to become unavailable in an emergency, list alternatives or instructions for each applicable family member along with the need. If medications are required, keep a copy of the prescription(s) with this plan for emergency reference.

Family Member _____ Physician 1 _____ Physician 2 _____ Physician 3 _____

Phone # _____ Phone # _____ Phone # _____

Date of Information: _____ Page # _____ of _____

Medication(s): _____ Online Source _____

Name _____ Dose _____ Time(s) _____ Source _____ ALT _____ Ordering Physician _____

Name _____ Dose _____ Time(s) _____ Source _____ ALT _____ Ordering Physician _____

Name _____ Dose _____ Time(s) _____ Source _____ ALT _____ Ordering Physician _____

Name _____ Dose _____ Time(s) _____ Source _____ ALT _____ Ordering Physician _____

Name _____ Dose _____ Time(s) _____ Source _____ ALT _____ Ordering Physician _____

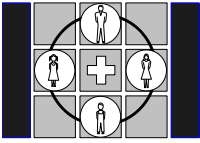
Name _____ Dose _____ Time(s) _____ Source _____ ALT _____ Ordering Physician _____

Name _____ Dose _____ Time(s) _____ Source _____ ALT _____ Ordering Physician _____

Name _____ Dose _____ Time(s) _____ Source _____ ALT _____ Ordering Physician _____

Special Testing Requirements/Schedule, Dietary & Treatment Notes:

ALT = Acquisition Lead Time (Days)



SCHOOL EMERGENCY PLAN

Seek a copy of the school emergency plan including their evacuation, shelter in place, and site disaster plan as it relates to you obtaining information on students when you can't get to the school and when you need to pick up your family member or other students on behalf of other parents.

A. Parent/Guardian Instructions for School Evacuations:

B. Parent/Guardian Instructions for School Site Disasters:

C. Parent/Guardian Instructions for Student Pick Up:

D. Criteria and Instructions for Non-Related Student Pick up:

School Data: Name _____ Phone # _____

Address: _____

School Data: Name _____ Phone # _____

Address: _____

School Data: Name _____ Phone # _____

Address: _____

School Administrative Office # _____

Friends/Relatives designated to pick up your family members: (be sure they are registered with/authorized by the school)

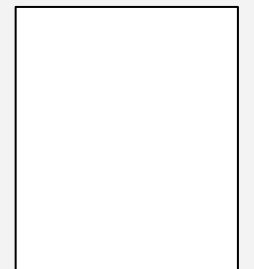
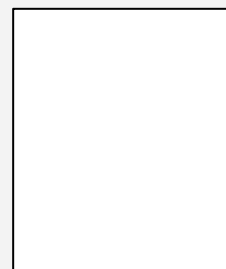
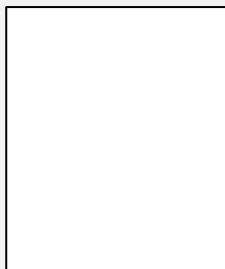
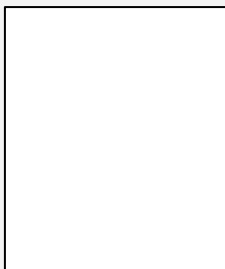
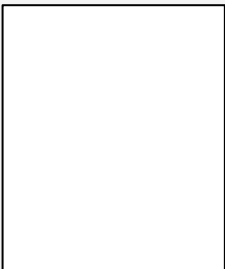
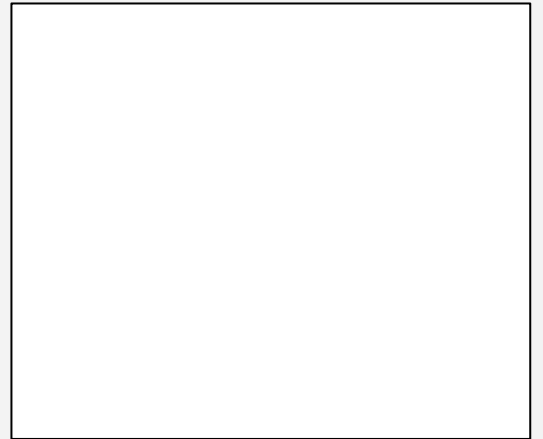
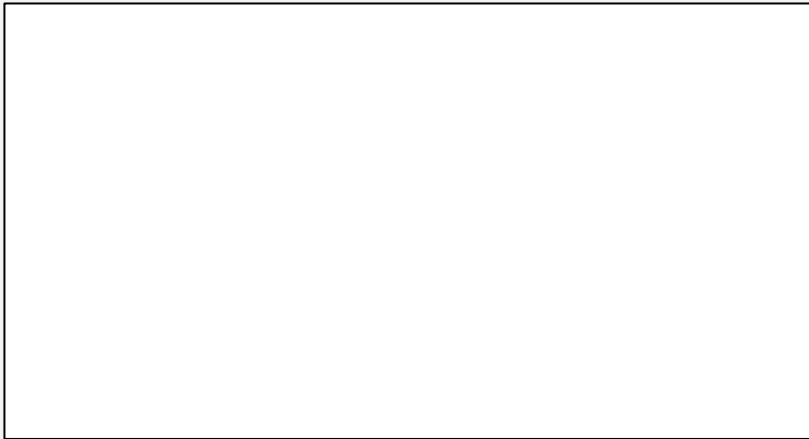
Name _____ Home Phone _____ Work Phone _____

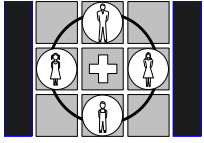
Name _____ Home Phone _____ Work Phone _____

Name _____ Home Phone _____ Work Phone _____

place school
campus map & student
schedules here

Place a current family photo and individual plan member photos here





PET EMERGENCY PLAN

If you are unable to get home to care for your pets: (Use neighbors, friends etc.)

Pet(s) have implanted ID tags: Phone number of service: _____

If you are home and need to take your pets with you in an evacuation:

Location of pet evacuation cage: _____

Place(s) to stay with pets: _____ Phone # _____

Alternate 1: _____ Phone # _____

Alternate 2: _____ Phone # _____

Your Pet Vet Clinic: _____ Phone # _____

Local 24hr Emergency Pet Hospital _____ Phone # _____

Address _____

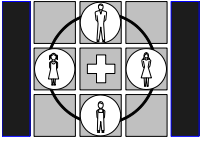
Directions _____

Special Needs for Pets: _____

If no one is available to assist at home pets or you are unable to keep your pets with you, contact the local animal control office at: _____

Complete pet ID tags in advance and have them ready to attach to your pet or pet cage for evacuation.





PLAN ACTIVATION

This section describes the required steps to make this plan document a functional action plan. Be sure to update the information and share the changes with each supporting family member, caregiver or friend.

Information Exchange:

Suggestion: Each individual or family should copy (or digitally scan) critical documents such as ID, deeds, birth certificates, bank/finance records, and home photos with inventory lists. Place a SECURE digital copy in the evacuation Go-Kit on a secure CD/DVD or secure USB drive

This data should also be placed in secure locations (in a data-secure format) in your home and with copies at other family member homes, a bank safe deposit box and/or a secure online back-up service.

Individuals associated with this plan: (list individuals in the order in which they will support your plan requirements)

- 1. Name: _____ Relationship: _____
- 2. Name: _____ Relationship: _____
- 3. Name: _____ Relationship: _____
- 4. Name: _____ Relationship: _____
- 5. Name: _____ Agency Support: _____

Validated:

Special Instructions For Family Members

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____