



FAACT's Disaster Resource Center

Emergency Health & Allergy Profile

Emergency Health and Allergy Profile for the _____ Household

HOUSEHOLD OVERVIEW

Last Name(s): _____

Primary Emergency Contact:

[Name and Phone Number]

Family Physician: _____
[Physician's Full Name] [Phone Number]

Family Pediatrician: _____
[Physician's Full Name] [Phone Number]

Preferred Emergency Facility: _____
[Hospital/Clinic Name]

Health Insurance: _____
Policy # [Policy Number] [Insurance Provider Name]

ADULTS

Adult Name: _____

Age: _____ Date of Birth: _____ Relationship to Family: _____

Food Allergies:

Medical Conditions:

[List Conditions]

Medications:

[List Medications and Dosages]

Special Notes:

[Any Additional Information]

Adult Name: _____

Age: _____ Date of Birth: _____ Relationship to Family: _____

Food Allergies:

Medical Conditions:

[List Conditions]

Medications:

[List Medications and Dosages]

Special Notes:

[Any Additional Information]

CHILDREN

Child #1: _____

Age: _____ Date of Birth: _____

Food Allergies: _____

Medical Conditions: _____

[List Conditions]

Medications: _____

[List Medications and Dosages]

Special Notes: _____

[Any Additional Information]

Child #2: _____

Age: _____ Date of Birth: _____

Food Allergies: _____

Medical Conditions: _____

[List Conditions]

Medications: _____

[List Medications and Dosages]

Special Notes: _____

[Any Additional Information]

Child #3: _____

Age: _____ Date of Birth: _____

Food Allergies: _____

Medical Conditions: _____

[List Conditions]

Medications: _____

[List Medications and Dosages]

Special Notes: _____

[Any Additional Information]