

## Our Family Communication Plan

Out-of-Town Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

**Complete for each member of your family living with you and keep the information current.**

Name, Date of Birth	Social Security Number and Important Medical Information such as Conditions and Allergies.

### Important Contact Numbers and Information

**Home:**

Address \_\_\_\_\_

Phone \_\_\_\_\_

**Work:**

Address \_\_\_\_\_

Phone \_\_\_\_\_

**School:**

Address \_\_\_\_\_

Phone \_\_\_\_\_

**Work:**

Address \_\_\_\_\_

Phone \_\_\_\_\_

**School:**

Address \_\_\_\_\_

Phone \_\_\_\_\_

**Daycare:**

Address \_\_\_\_\_

Phone \_\_\_\_\_

**School:**

Address \_\_\_\_\_

Phone \_\_\_\_\_

**Other place you frequent:**

Address \_\_\_\_\_

Phone \_\_\_\_\_

Important Information	Name	Telephone #	Policy #
<b>Doctor(s):</b>			
<b>Pharmacy</b>			
<b>Health Insurance</b>			
<b>Homeowners Insurance</b>			
<b>Veterinarian/ Kennel</b>			

**9-1-1 for Emergencies**

Police Non-Emergency Phone Number: \_\_\_\_\_

Other: \_\_\_\_\_

Each family member should carry a copy of this with them. Clip and place in wallet.  
HC-POA = Health care power of attorney. Enter name if you have designated person to hold HC-POA.

Personal Health Information		Personal Health Information	
Name: _____ Emergency Contact Name & Phone: _____		Name: _____ Emergency Contact Name & Phone: _____	
Blood Type:	Allergies:	Blood Type:	Allergies:
Medications:		Medications:	
Donor:		Donor:	
HC-POA:		HC-POA:	
Doctor:			

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Blood Type:	Allergies:	Blood Type:	Allergies:
Medications:		Medications:	
Donor:		Donor:	
HC-POA:		HC-POA:	
Doctor:			

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Donor:		Donor:	
HC-POA:		HC-POA:	
Doctor:			