

This Plan is being completed for  
the following individual or family:

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_



## Emergency Contacts

It is important to update this information if it  
changes. Please note the date changes are made.

First Contact Name \_\_\_\_\_

Telephone Number \_\_\_\_\_

Email Address \_\_\_\_\_

Relationship \_\_\_\_\_

Second Contact Name \_\_\_\_\_

Telephone Number \_\_\_\_\_

Email Address \_\_\_\_\_

Relationship \_\_\_\_\_

# IMPORTANT INFORMATION

DATE \_\_\_\_\_

This plan is being completed for the following individual or family. Provide the same information for each family member. Use additional paper if needed.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Blood Type \_\_\_\_\_

Address \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Telephone \_\_\_\_\_ Address \_\_\_\_\_

Other Doctor's Name \_\_\_\_\_ Telephone \_\_\_\_\_ Address \_\_\_\_\_

Pharmacist \_\_\_\_\_ Telephone \_\_\_\_\_ Address \_\_\_\_\_

Medical Insurance \_\_\_\_\_ Telephone \_\_\_\_\_ Policy/Account Number \_\_\_\_\_

Life Insurance \_\_\_\_\_ Telephone \_\_\_\_\_ Policy/Account Number \_\_\_\_\_

Home/Rental Insurance \_\_\_\_\_ Telephone \_\_\_\_\_ Policy/Account Number \_\_\_\_\_

Personal Care Attendant \_\_\_\_\_ Telephone \_\_\_\_\_ Email \_\_\_\_\_

Service Animal Name \_\_\_\_\_ Breed \_\_\_\_\_ Vaccination Dates \_\_\_\_\_

Veterinarian Info \_\_\_\_\_ Telephone \_\_\_\_\_ Email \_\_\_\_\_

Kennel Information \_\_\_\_\_ Telephone \_\_\_\_\_ Contact Name \_\_\_\_\_



## MEDICAL CONDITIONS

Include information such as diabetes, heart condition, etc.

Condition/Disability: \_\_\_\_\_

Condition/Disability: \_\_\_\_\_

Condition/Disability: \_\_\_\_\_

Condition/Disability: \_\_\_\_\_



## ALLERGIES

Use additional paper if necessary.

Allergy: \_\_\_\_\_

What happens: \_\_\_\_\_

Allergy: \_\_\_\_\_

What happens: \_\_\_\_\_

Allergy: \_\_\_\_\_

What happens: \_\_\_\_\_



# MEDICATIONS

Use additional paper if necessary.

**Name of Medication:** \_\_\_\_\_

Reason: \_\_\_\_\_

Dose and Schedule: \_\_\_\_\_

**Name of Medication:** \_\_\_\_\_

Reason: \_\_\_\_\_

Dose and Schedule: \_\_\_\_\_

**Name of Medication:** \_\_\_\_\_

Reason: \_\_\_\_\_

Dose and Schedule: \_\_\_\_\_

**Name of Medication:** \_\_\_\_\_

Reason: \_\_\_\_\_

Dose and Schedule: \_\_\_\_\_



# MEDICAL EQUIPMENT

Include information such as wheelchair, hearing aids, oxygen, etc.

**Type of Equipment:** \_\_\_\_\_

**Type of Equipment:** \_\_\_\_\_

**Type of Equipment:** \_\_\_\_\_

**Type of Equipment:** \_\_\_\_\_

**It is important to update this information if it changes,  
and note the date changes are made.**