

# My Emergency Care Plan

## Information About Me

Date Completed

Name  Birth date  Address

### My Communication Needs

### My Disabilities, Diagnoses, or Other Health Conditions

### My Medical Equipment

### My Support Person

Name

Phone

Email

Relationship to Me

### My Advance Care Directive

I have (1) signed an Advance Health Care Directive, (2) designated a *health care agent*, and (3) given that person a copy of my directive. **Name & contact information** of my *health care agent* is:

I do not have an Advance Health Care Directive, but I want to name someone as my *surrogate decision maker* for health care decisions. **Name & contact information** of my *surrogate decision maker* is:

Additional Information Continued on Back of Form



## Critical Information for Treating Me

### My Healthcare Team

Name & Contact Information of My Providers

### My Medications

Medications/Schedules/Doses/Reasons

Additional Information Continued on Back of Form



UNIVERSITY OF DELAWARE  
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