My Health Care Plan

Attach my photo

About Me

Name ______________________

Birthday ______________________

Health Insurance ______________________

Blood Type ______________________

My Support Person

Name ______________________

Phone ______________________

Email ______________________

My Conditions

Any disabilities or other health conditions:

Any special care instructions:

continued on back

I Communicate By: (Check all that apply)

- [ ] Talking
- [ ] Writing or typing
- [ ] Using sign language
- [ ] Using a device
- [ ] Pointing to words
- [ ] Pointing to pictures
- [ ] Using gestures/body

Other ways I communicate:

I understand these languages

Inside Pages:

Medical Profile

My Equipment / Devices....3

Allergies....3

Immunizations....3

Pharmacies 3

Medications....4

Physicians / Providers....5

Surgical History....5

Personal Profile

Advance Care Directive....6

Person(s) to consult about my Health 6

I need help with 6

How I express myself....6

My strengths 7

My challenges....7

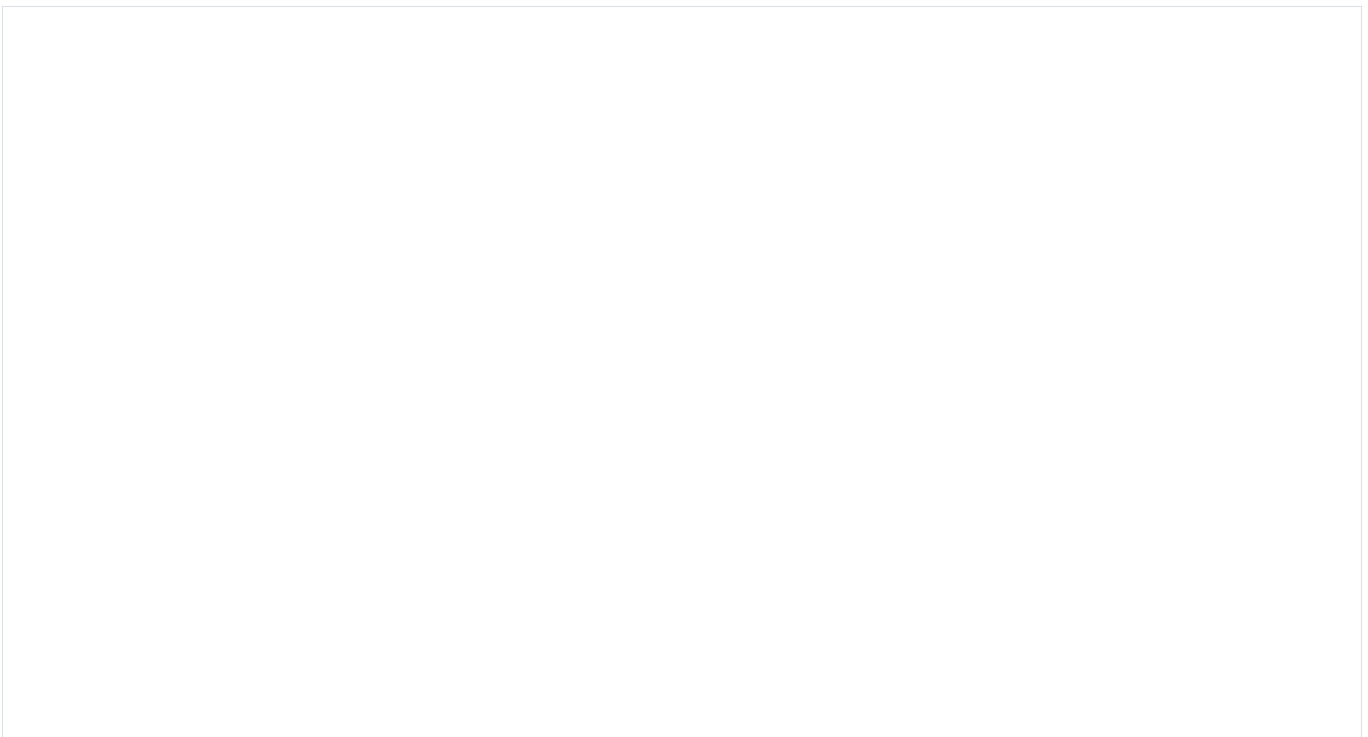
Person(s) to consult about my

Pet or service animal 7

Home groceries/meal prep ..7

Use the space below to provide more information about your disabilities/health conditions:

Use the space below to provide more special care instructions:



Medical Profile

My Equipment/Devices (Check all that apply)

- [ ] Braces / orthodics
- [ ] Hearing Aids
- [ ] Reading device / aid
- [ ] Walker / cane
- [ ] Communication devices
- [ ] Home oxygen
- [ ] Service animal
- [ ] Wheelchair
- [ ] Glasses
- [ ] Insulin Pump
- [ ] Suction
- [ ] Writing device / aid
- [ ] Other

Allergies

Type

Food

Medicines

Other

Reactions/Symptoms

*Special Diet:
If yes, explain below:

- [ ] Yes
- [ ] No

Immunizations Received

- [ ] COVID-19 (**Fully vaccinated**)
- [ ] Chickenpox (Varicella)
- [ ] Haemophilus influenzae type b (Hib)
- [ ] Measles, mumps, rubella (MMR)
- [ ] Pneumococcal (PCV)
- [ ] Hepatitis B (HepB)
- [ ] COVID-19 (**Partially vaccinated**)
- [ ] Diphtheria, tetanus, & whooping cough (pertussis) (DTaP)
- [ ] Influenza (current season)
- [ ] Polio (IPV) (between 6 through 18 months)
- [ ] Hepatitis A (HepA)

List any other vaccinations:

Pharmacies

Name ______________________

Address ______________________

Phone # ____________ Fax # ____________

Name ______________________

Address ______________________

Phone # ____________ Fax # ____________

Medications

Medication name: ______________________________ Dosage and frequency: ___________________________

How I take it:______________________________________ Why I take it: _____________________________________

Medication name: ______________________________ Dosage and frequency: ___________________________

How I take it:______________________________________ Why I take it: _____________________________________

Medication name: ______________________________ Dosage and frequency: ___________________________

How I take it:______________________________________ Why I take it: _____________________________________

Medication name: ______________________________ Dosage and frequency: ___________________________

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Medication name: ______________________________ Dosage and frequency: ___________________________

How I take it:______________________________________ Why I take it: _____________________________________

Medication name: ______________________________ Dosage and frequency: ___________________________

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Medication name: ______________________________ Dosage and frequency: ___________________________

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Medication name: ______________________________ Dosage and frequency: ___________________________

How I take it:______________________________________ Why I take it: _____________________________________

Medication name: ______________________________ Dosage and frequency: ___________________________

How I take it:______________________________________ Why I take it: _____________________________________

Medical Profile

Physicians / Providers

Name: ____ Name: ____
Specialty: ____ Specialty: ____
Phone #: ____ Phone #: ____

Name: ____ Name: ____
Specialty: ____ Specialty: ____
Phone #: ____ Phone #: ____

Name: ____ Name: ____
Specialty: ____ Specialty: ____
Phone #: ____ Phone #: ____

Name: ____ Name: ____
Specialty: ____ Specialty: ____
Phone #: ____ Phone #: ____

Surgical History

(Start with most recent procedure)

Type: ____ Type: ____
When: ____ When: ____

Type: ____ Type: ____
When: ____ When: ____

Type: ____ Type: ____
When: ____ When: ____

Type: ____ Type: ____
When: ____ When: ____

Personal Profile

Advance Care Directive

☐ I have signed an advance health care directive, designated a health care agent and gave that person a copy of the directive.

My designated health care agent is:

____

☐ I do not have an advance health care directive but want to name someone to be my surrogate decision maker for health care decisions.

My surrogate decision maker for health care is:

____

Person(s) to Contact About My Health:

(Examples: aides, family, neighbor, or friend)

I Need Help With:

(Check all that apply) ☐ Eating ☐ Drinking ☐ Washing ☐ Bathroom ☐ Dressing

Other things I need help with:

How I express myself:

I might get upset from: (examples: noises, lighting, being touched, smells, face masks)

When I am anxious or stressed, I feel better when:

When I am hurt or sick, I feel better when:

When I am in pain, I show it by:

Personal Profile

My Strengths:

(What comes easy for me or something I am proud of):

My Challenges:

(Examples: communication, feeding, learning, mobility, social, energy, behavior):

Person(s) to Contact About My Pet or Service Animal:

(Examples: family member, aide, neighbor or friend. Include name(s) and phone number(s).)

Person(s) to Contact About My Home Groceries / Meal Prep:

(Examples: family member, aide, neighbor or friend. Include name(s) and phone number(s).)

UNIVERSITY OF DELAWARE
CENTER FOR DISABILITIES STUDIES

University of Delaware, College of Education and Human Development, 461 Wyoming Road, Newark, DE 19716 · 302-831-6974 · 302-831-4689 TDD · cds.udel.edu

Developmental Disabilities Council, Margaret M. O'Neill Building, Suite 2, 410 Federal Street, 2nd Floor, Dover, DE 19901 · 302-739-3333 302-739-2015 TDD · ddc.delaware.gov

My Strengths (continued):

My Challenges (continued):

Person(s) to Contact About My Pet or Service Animal (continued):

Person(s) to Contact About My Home Groceries / Meal Prep (continued):