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

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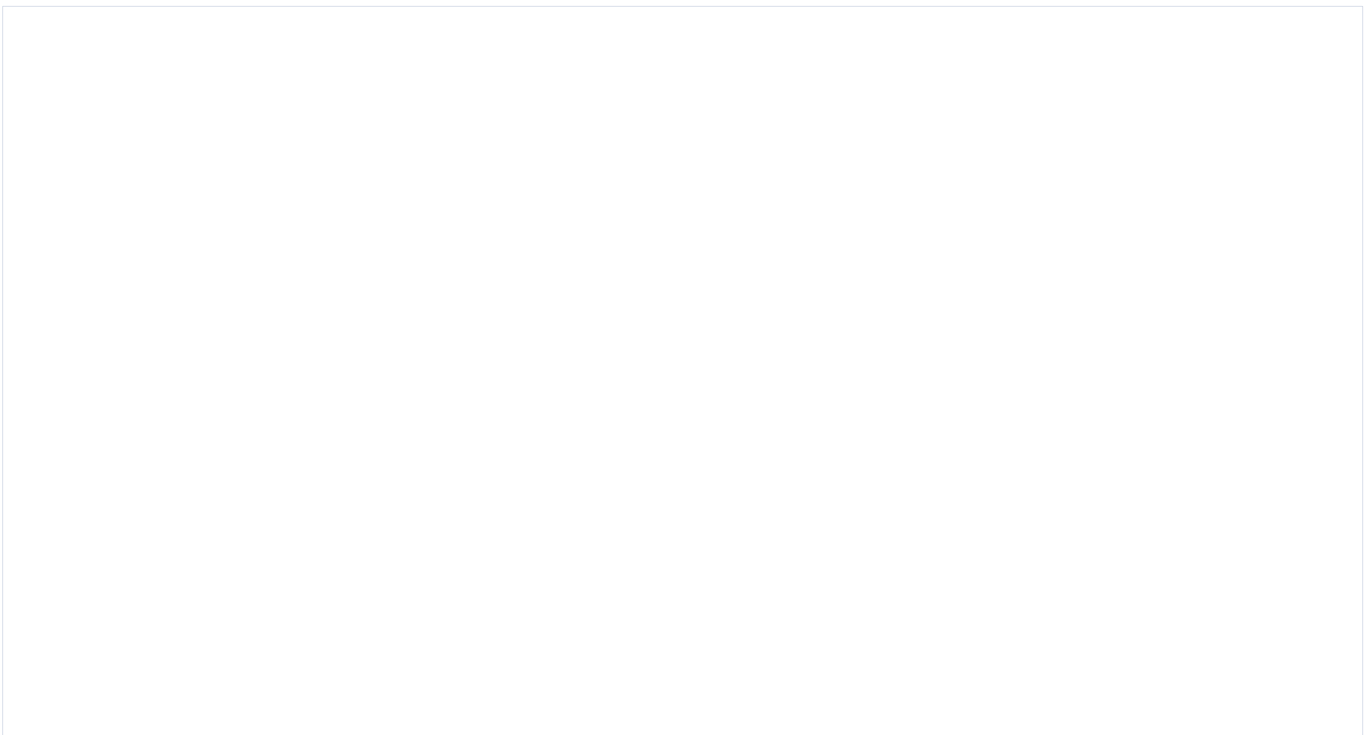
Use the space below to provide more information about your disabilities/health conditions:

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 # ____________

Medical Profile

Medications

Medication name: ______________________________ Dosage and frequency: ___________________________
How I take it:_____________________________________ Why I take it: _____________________________________

Medication name: ______________________________ Dosage and frequency: ___________________________
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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):