



Invisible Children's Project

- Information for Parents -

Sample Emergency Plan for Caregivers (Not a Legal Document)

1. **Mental Health Emergency Plan for** _____ (your name).

2. **Is another parent available to take care of your children?**

If yes, Name _____

Address _____

Phone Number _____

In case of a Mental Health Emergency this person has agreed to temporarily take care of my children:

Name _____

Address _____

Home Phone _____ Cell Phone _____

Work phone _____

I give my permission to _____ to temporarily take care of my children until I say differently, including medical and school matters.

Insurance Information:

() My children have health insurance coverage.

Name of insurance company _____

Identification Number _____

() My children do not have insurance coverage.

3. Information About Your Children

Children 1: Name _____

Bedtime _____

Special Needs _____

School and School Address _____

Times for the school day. Start _____ End _____

After school care? Place _____

Address _____ Phone _____

Medicine _____ Times taken _____

Medicine _____ Times taken _____

Children 2: Name _____
Bedtime _____
Special Needs _____
School and School Address _____
Times for the school day. Start _____ End _____
After school care? Place _____
Address _____ Phone _____
Medicine _____ Times taken _____
Medicine _____ Times taken _____

Children's Physician _____ Phone number _____
Children's Therapist or Counselor _____ Phone number _____

(Use an additional sheet if you have more children.)

4. Information about You:

Your full legal name: _____
Address: _____
City _____ State _____ Zip _____
Phone number _____
Social Security Number _____ Date of Birth _____

Insurance Information:

I have insurance coverage with _____
Identification number _____
 I do not have insurance coverage.

In a mental health emergency I would like the following people to be called:

Other parent _____ Phone _____
Family member _____ Phone _____
Family member _____ Phone _____
Friend _____ Phone _____
Other _____ Phone _____

My preferences for mental health services are:

Doctor _____ Phone _____
Therapist/Counselor _____ Phone _____
Facility _____ Phone _____
Emergency – Call 911

5. Signature

Signed _____ Date _____

6. Optional

Witness _____ Date _____