

Plan to Be Safe Checklist

Plan to be safe.

Goal: To have the client achieve a 3 day supply of the 9 essential items necessary for emergency preparedness.

Client Name: _____

Aide Name: _____

Plan 9

Please place a checkmark in the appropriate box. The date of review is at the start of service and within 30 days of the start of service. Subsequent reviews are to take place each subsequent October and April. Please note in the narrative section any concerns.

Plan 9 Item	1 st Day ____/____/____			30 th Day ____/____/____			April ____/____/____			October ____/____/____		
	None	Partial 3 Day Supply	3 Day Supply	None	Partial 3 Day Supply	3 Day Supply	None	Partial 3 Day Supply	3 Day Supply	None	Partial 3 Day Supply	3 Day Supply
Water (one gallon per person per day)												
Food (non-perishable)												
Clothes (Think of seasonal items)												
Prescription Medications (Include fever relief meds)												
Flashlight (Extra batteries)												
Manual Can Opener												
Radio (with extra batteries)												
Hygiene Items (toothbrush, toilet paper, etc.)												
First Aid Kit (Band-Aids, Pain meds, Neosporin)												
Narrative												

Supplemental Sheet

Plan 9 Item	_ / _ / _			_ / _ / _			_ / _ / _			_ / _ / _		
	None	Partial 3 Day Supply	3 Day Supply	None	Partial 3 Day Supply	3 Day Supply	None	Partial 3 Day Supply	3 Day Supply	None	Partial 3 Day Supply	3 Day Supply
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