



ACT
Government

YOUR EMERGENCY GRAB AND GO BOOKLET

YOUR DETAILS

Name

Address

Telephone

Postcode

H

M

W

Email

EMERGENCY AND ACT INFORMATION

Police, Fire Brigade or Ambulance

000

Police Assistance Line

131 444

SES (for assistance in storms or flood)

132 500

Crimestoppers

1800 333 000

Translating and Interpreting Service

131 450

Canberra Connect

132 281

healthdirect Australia

1800 022 222

THINK AHEAD | BE READY | STAY SAFE

YOUR EMERGENCY KIT CONTENTS

To ensure you are prepared in case of an emergency, it is important to put together a kit of essential items.

WHAT TO INCLUDE IN YOUR KIT

You should consider including:

- | | | |
|--|---|--|
| <input type="checkbox"/> battery operated radio | <input type="checkbox"/> change of clothing | <input type="checkbox"/> long-life snacks and water |
| <input type="checkbox"/> torch | <input type="checkbox"/> woollen blanket | <input type="checkbox"/> spare house and/or car keys |
| <input type="checkbox"/> spare batteries for torch and radio | <input type="checkbox"/> First Aid kit | <input type="checkbox"/> list of important contacts |
| <input type="checkbox"/> small quantity of money | <input type="checkbox"/> candles and waterproof matches | |

WHERE WILL YOU KEEP THE KIT?

Write down where in your house you will keep your kit

WHAT WILL YOU NEED TO ADD TO YOUR KIT IF YOU HAVE TO EVACUATE?

If you need to leave your house because of an emergency you may need to add to your kit:

- | | |
|---|---|
| <input type="checkbox"/> medication | <input type="checkbox"/> photos or disk with photos |
| <input type="checkbox"/> prescriptions | <input type="checkbox"/> street directory/map |
| <input type="checkbox"/> your medication record | <input type="checkbox"/> mobile phone |
| <input type="checkbox"/> important papers or documents such as, | <input type="checkbox"/> mobile phone charger |
| <input type="checkbox"/> insurance policy | <input type="checkbox"/> reading glasses |
| <input type="checkbox"/> passport | <input type="checkbox"/> drivers licence |

YOUR EMERGENCY EVACUATION PLAN

Prepare a plan of action for leaving your house during an emergency. Think about the following:

- Is your emergency kit ready to go at any time?
- Are your Medication and Contact cards up-to-date?
- What other essentials do you need to take with you when you leave?
- Have you told your neighbours what you are doing?
- If you have pets, what arrangements will be made for them?

BEFORE YOU LEAVE (IF YOU HAVE TIME)

Turn off gas, electricity and water supply, or let someone know where they can do this.

Gas meter	<input type="text" value="LOCATION"/>
Electricity mains	<input type="text" value="LOCATION"/>
Water meter	<input type="text" value="LOCATION"/>

WHERE WILL YOU GO?

Option 1

Option 2

How will you get there?

Who can help you? Tel

Who else do you need to tell if you are leaving your house?

Name Tel

Are there any essential/regular commitments that someone needs to do for you?

EMERGENCY CONTACTS

YOUR FAMILY AND FRIENDS

1

Name

Relationship

Address

Postcode

Telephone H M W

2

Name

Relationship

Address

Postcode

Telephone H M W

3

Name

Relationship

Address

Postcode

Telephone H M W

4

Name

Relationship

Address

Postcode

Telephone H M W

EMERGENCY CONTACTS YOUR NEIGHBOURS

1 Name

Address

Postcode

Telephone H M W

2 Name

Address

Postcode

Telephone H M W

3 Name

Address

Postcode

Telephone H M W

4 Name

Address

Postcode

Telephone H M W

5 Name

Address

Postcode

Telephone H M W

OTHER CONTACTS

UTILITY PROVIDERS

Electricity

Tel

Natural gas

Tel

Water /sewage

ActewAGL water and wastewater emergency

Tel

131 193

Stormwater

ACT Department of Territory and Municipal Services

Tel

132 281

TRADEPEOPLE

Plumber

Telephone

Mobile

Electrician

Telephone

Mobile

INSURANCE

Home & contents

Telephone

Fax

Medical

Telephone

Fax

Motor vehicle

Telephone

Fax

OTHER

Tel

Tel

Tel

YOUR MEDICAL INFORMATION

PERSON 1

Name

Date of birth

 / /

Blood type

Medical allergies

Doctor

Telephone

Dentist

Telephone

Pharmacy

Telephone

Glasses/contact lenses?

Dentures?

Diabetic?

Epileptic?

Medical condition

Medication

Dosage

Medical condition

Medication

Dosage

Medical condition

Medication

Dosage

Medical condition

Medication

Dosage

Medical condition

Medication

Dosage

YOUR MEDICAL INFORMATION

PERSON 2

Name

Date of birth

 / /

Blood type

Medical allergies

Doctor

Telephone

Dentist

Telephone

Pharmacy

Telephone

Glasses/contact lenses?

Dentures?

Diabetic?

Epileptic?

Medical condition

Medication

Dosage

Medical condition

Medication

Dosage

Medical condition

Medication

Dosage

Medical condition

Medication

Dosage

Medical condition

Medication

Dosage