

DISABILITY EMERGENCY PLANNING QUIZ



Do you have	YES	NO
limitations that affect your balance?	<input type="checkbox"/>	<input type="checkbox"/>
limitations that affect your walking?	<input type="checkbox"/>	<input type="checkbox"/>
limitations that require special devices such as a wheel chair, walker, cane?	<input type="checkbox"/>	<input type="checkbox"/>
limitations that affect your energy or endurance level?	<input type="checkbox"/>	<input type="checkbox"/>
limitations that affect your breathing?	<input type="checkbox"/>	<input type="checkbox"/>
limitations that affect your thinking abilities?	<input type="checkbox"/>	<input type="checkbox"/>
limitations that affect your ability to hear emergency sounds?	<input type="checkbox"/>	<input type="checkbox"/>
limitations that affect your ability to see exits?	<input type="checkbox"/>	<input type="checkbox"/>
limitations that affect your ability to feel or touch things?	<input type="checkbox"/>	<input type="checkbox"/>
Do you	YES	NO
have temporary limitations such as from surgery, accidents, injuries?	<input type="checkbox"/>	<input type="checkbox"/>
rely on assistive devices to get around such as a wheel chair or canes?	<input type="checkbox"/>	<input type="checkbox"/>
rely on hearing aids to hear?	<input type="checkbox"/>	<input type="checkbox"/>
rely on glasses or other devices to see?	<input type="checkbox"/>	<input type="checkbox"/>
rely on oxygen tanks to breathe?	<input type="checkbox"/>	<input type="checkbox"/>
rely on any special technology to survive?	<input type="checkbox"/>	<input type="checkbox"/>

Any YES answer indicates you are an AT RISK individual. Multiple YES answers indicate a critical need to make advance plans in the event of an emergency.

Do you	YES	NO
know where to evacuate to in an emergency?	<input type="checkbox"/>	<input type="checkbox"/>
know who to contact if you need help in an emergency?	<input type="checkbox"/>	<input type="checkbox"/>
have family or friends you can call in the event of an emergency?	<input type="checkbox"/>	<input type="checkbox"/>
Could you survive	YES	NO
without electricity for three or more days?	<input type="checkbox"/>	<input type="checkbox"/>
without medication for three or more days?	<input type="checkbox"/>	<input type="checkbox"/>
without assistive devices for three or more days?	<input type="checkbox"/>	<input type="checkbox"/>

Any NO answer indicates you are an AT RISK individual. Multiple NO answers indicate a critical need to make advance plans in the event of an emergency.