

MECOSTA COUNTY EMERGENCY MANAGEMENT

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Family Disaster Guide

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About your Family Disaster Guide

Emergencies can strike at any time without warning, leaving little or no time for you and your family to plan. It is our goal that with this plan, families, neighborhoods and local communities can improve their safety by working together.

Local officials and relief workers will be on the scene after a disaster, but they cannot reach everyone right away. It is necessary to learn about the things that you can do to be prepared before an emergency occurs. Following the steps in this guide will help you in creating your family's disaster plan.

Knowing what to do is your best protection and responsibility.

This Guide will help you develop:

1. An emergency plan
2. Information on how to assemble an Emergency Supply Kit
3. Specific contact telephone numbers.

When An Emergency Strikes

During and after an emergency occurs, it is important to stay calm. Even after an event, there may still be many dangers and what seems like a safe distance or location may not be. **Stay tuned to your local emergency station and follow the advice of trained professionals.** Unless told to evacuate, avoid roads to allow emergency vehicles access. What you do next can save your life and the lives of others.

During an emergency you might be cut off from food, water and electricity for several days or more. If power is out, food stores may be closed and your water supply may not work. Here are some suggestions:

Water: If a disaster catches you without a supply of clean water, you can use ice cubes and the water in your hot water tank or pipes. If it is safe to go outside, you can also purify water from streams or rivers, rainwater, ponds and lakes, natural springs and snow by boiling (for 5 minutes), distilling or disinfection. To purify water with bleach, use 10 drops of bleach per gallon of water. Use only regular household liquid bleach that contains only 5.25% sodium hypochlorite.

Food: During and right after an emergency, it will be important that you keep up your strength by eating at least one well-balanced meal each day. Take vitamin, mineral and/or protein supplements.

If Your Power Goes Out:

- ___ Remain calm, and assist family members or neighbors who may be vulnerable if exposed to extreme heat or cold.
- ___ Locate a flashlight with batteries to use until power comes back on. **Do not** use candles—this can cause a fire.
- ___ Turn off sensitive electric equipment such as computers, VCRs, and televisions.
- ___ Turn off major electric appliances that were on when the power went off. This will help to prevent power surges when electricity is restored.
- ___ Keep your refrigerator and freezer doors closed as much as possible to keep cold in.
- ___ **Do not** use the stove to heat your home - this can cause a fire or fatal gas leak.
- ___ Use extreme caution when driving. If traffic signals are out, treat each signal as a stop sign—come to a complete stop at every intersection and look before you proceed.
- ___ **Do not** call 9-1-1 to ask about the power outage. Listen to the news radio stations for updates.

If You Have Pets: (survival kit for your pet)

- ___ Identification collar, rabies tag and leash.
- ___ Carrier or cage.
- ___ Any medications (be sure to check expiration dates).
- ___ Newspapers and plastic trash bags for handling waste.
- ___ At least a 2-week supply of food, water, and food bowls.
- ___ Veterinary records

Preparing an Emergency Supply Kit

You should gather water, food, first-aid supplies, clothing, bedding, tools and other essentials ahead of time and be ready in the event you must evacuate or go without electricity, heat, or water for an extended period. The kit can be put into 5-gallon buckets, duffel bags, or backpacks.

Consider including the following items in an Emergency Supply Kit

Water: (3-day supply of water stored in sealed, unbreakable containers)

1 gallon per person per day. Replace every 6 months.

Food: (3- to 5-day supply of nonperishable packaged or canned food per person)

- | | |
|---|---|
| <input type="checkbox"/> Ready to eat canned meats, fruits & vegetables | <input type="checkbox"/> Smoked or dried meats (beef jerky) |
| <input type="checkbox"/> Soups-bouillon cubes or dried soups in a cup | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Milk-powdered or canned | <input type="checkbox"/> High energy foods (nuts) |
| <input type="checkbox"/> Stress foods-sugar cookies, hard candy | <input type="checkbox"/> Sugar, salt, pepper |
| <input type="checkbox"/> Juices-canned, powdered or crystallized | |

Clothing & Bedding: (Include at least one change of clothing and footwear per person)

- | | |
|---|---|
| <input type="checkbox"/> Sturdy shoes or work boots | <input type="checkbox"/> Hats & gloves, extra warm clothing |
| <input type="checkbox"/> Warm socks, rain gear | <input type="checkbox"/> Thermal underwear |
| <input type="checkbox"/> Blankets or sleeping bags | <input type="checkbox"/> Sunglasses |

First Aid Kit:

- | | |
|---|--|
| <input type="checkbox"/> Sterile adhesive bandages | <input type="checkbox"/> Bar of soap |
| <input type="checkbox"/> 3-inch sterile gauze pads (8-12) | <input type="checkbox"/> Moistened towelettes |
| <input type="checkbox"/> Triangular bandages (3) | <input type="checkbox"/> Antiseptic spray |
| <input type="checkbox"/> 2-inch sterile gauze pads (8-12) | <input type="checkbox"/> Non-breakable thermometer |
| <input type="checkbox"/> Hypoallergenic adhesive tape | <input type="checkbox"/> Latex gloves |
| <input type="checkbox"/> 2 & 3-inch sterile roller bandages | <input type="checkbox"/> Petroleum jelly |
| <input type="checkbox"/> Scissors | <input type="checkbox"/> Assorted sizes of safety pins |
| <input type="checkbox"/> Tweezers | <input type="checkbox"/> Cleansing agent –soap |
| <input type="checkbox"/> Needles | <input type="checkbox"/> Wooden applicator sticks |
| <input type="checkbox"/> Safety razor blade | <input type="checkbox"/> Water purification tablets |

Tools & Supplies:

- | | |
|--|--|
| <input type="checkbox"/> Mess kits, paper cups, plastic utensils | <input type="checkbox"/> Maps (state, county, city) |
| <input type="checkbox"/> Batteries, battery operated radio | <input type="checkbox"/> Fire extinguisher |
| <input type="checkbox"/> Flashlight, extra bulbs, extra batteries | <input type="checkbox"/> Money |
| <input type="checkbox"/> Wooden matches in waterproof container | <input type="checkbox"/> Family emergency plan |
| <input type="checkbox"/> Aluminum foil, plastic storage containers | <input type="checkbox"/> Can opener (hand-operated) |
| <input type="checkbox"/> Signal flare | <input type="checkbox"/> Utility knife, paper towels |
| <input type="checkbox"/> Paper, pencil and needles, thread | <input type="checkbox"/> Tube tent/tarp |
| <input type="checkbox"/> Shovel & other useful tools | <input type="checkbox"/> Medicine dropper |
| <input type="checkbox"/> Plastic sheeting, duct tape | <input type="checkbox"/> Dust mask and work gloves |

Sanitation:

- Personal hygiene items
- Plastic garbage bags and ties
- Plastic bucket w/tight lid

- Spray disinfectant
- Towelettes or diaper wipes
- Toilet paper

Special Items: (For Baby)

- Bottles
- Powdered milk
- Medications

- Formula, Juice
- Diapers/wipes

For Adult:

- Heart and high blood pressure medications
- Insulin
- Prescription drugs
- Denture needs
- Contact lenses and supplies

- Extra eyeglasses
- Entertainment –games, books
- Cell phone
- Prepaid phone card

Important Family Documents: (Keep copies in the emergency supply kit.)

- Important phone numbers
- Wills, insurance policies
- Contracts, deeds, stocks and bonds
- Passports, social security cards

- Immunizations records
- Family records (birth, marriage)
- Inventory of valuables (household)
- Ownership/ Vehicle Registration

Emergency Telephone Numbers

Local Contact:

Name _____
City _____
Telephone (day) () - _____ (evening) () - _____
Cellular Phone () - _____

Out of Area Contact:

Name _____
City _____
Telephone (day) () - _____ (evening) () - _____
Cellular Phone () - _____

Nearest Relative:

Name _____
City _____
Telephone (day) () - _____ (evening) () - _____
Cellular Phone () - _____

Family Work Numbers:

Father _____
Mother _____
Other _____

Local Emergency Numbers:

Police Department _____
Fire Department _____
Hospital _____

Family Physicians:

Name _____	Telephone _____
Name _____	Telephone _____
Name _____	Telephone _____

Reunion Locations:

1. Right outside your home _____

2. Away from the neighborhood, in case you cannot return home

Address _____
Telephone _____
Route to try first _____

Utilities:

Electric Company _____	Telephone Company _____
Gas Company _____	Water Company _____
Cable TV Company _____	

Additional Emergency Numbers

Emergency help number

911 or local emergency dispatch

Michigan Poison Control Center

1-800-222-1222 also (TDD)

Downed power lines for Consumers Energy

1-800-477-5050

DTE Energy

1-800-477-4747

Coast Guard Emergency Service

1-800-321-4400

Center For Disease Control

(CDC) 404-639-3311

EPA Haz Waste Hotline

1-800-621-8431

National Pesticide Network

1-800-858-7378 (24 HRS)

Agricultural Spills in Michigan

517-373-0440

Family Medication Information

Medical information on Family/Household Member (1)

Fill out one sheet for each family member whether or not they are on medication

<u>Person's name</u>	<u>Medication Name</u>	<u>Dosage/ Frequency</u>	<u>Reason for Taking</u>
<u>Doctor</u>	<u>Prescription#</u>	<u>Date Started/Ending</u>	<u>Location of Medicine</u>
<u>Pharmacist</u>	<u>Pharmacy Name</u>	<u>Phone</u>	<u>Address</u>
<u>Specialists</u>	<u>Area of Concern</u>	<u>Organization</u>	<u>Phone/Address</u>
<u>Allergies to Medications</u>	<u>Health /Disability information</u>	<u>Special needs, Equipment and supplies</u>	<u>Other information</u>

Note: Keep on hand at least seven days of vital medications and supplies. Check with your doctor on long term storage or if you use more than one medication

Medical information on Family/Household Member (2)

Fill out one sheet for each family member whether or not they are on medication

<u>Person's name</u>	<u>Medication Name</u>	<u>Dosage/ Frequency</u>	<u>Reason for Taking</u>
<u>Doctor</u>	<u>Prescription#</u>	<u>Date Started/Ending</u>	<u>Location of Medicine</u>
<u>Pharmacist</u>	<u>Pharmacy Name</u>	<u>Phone</u>	<u>Address</u>
<u>Specialists</u>	<u>Area of Concern</u>	<u>Organization</u>	<u>Phone/Address</u>
<u>Allergies to Medications</u>	<u>Health /Disability information</u>	<u>Special needs, Equipment and supplies</u>	<u>Other information</u>

Note: Keep on hand at least seven days of vital medications and supplies. Check with your doctor on long term storage or if you use more than one medication

Medical information on Family/Household Member (3)

Fill out one sheet for each family member whether or not they are on medication

<u>Person's name</u>	<u>Medication Name</u>	<u>Dosage/ Frequency</u>	<u>Reason for Taking</u>
<u>Doctor</u>	<u>Prescription#</u>	<u>Date Started/Ending</u>	<u>Location of Medicine</u>
<u>Pharmacist</u>	<u>Pharmacy Name</u>	<u>Phone</u>	<u>Address</u>
<u>Specialists</u>	<u>Area of Concern</u>	<u>Organization</u>	<u>Phone/Address</u>
<u>Allergies to Medications</u>	<u>Health /Disability information</u>	<u>Special needs, Equipment and supplies</u>	<u>Other information</u>

Note: Keep on hand at least seven days of vital medications and supplies. Check with your doctor on long term storage or if you use more than one medication

Medical information on Family/Household Member (4)

Fill out one sheet for each family member whether or not they are on medication

<u>Person's name</u>	<u>Medication Name</u>	<u>Dosage/ Frequency</u>	<u>Reason for Taking</u>
<u>Doctor</u>	<u>Prescription#</u>	<u>Date Started/Ending</u>	<u>Location of Medicine</u>
<u>Pharmacist</u>	<u>Pharmacy Name</u>	<u>Phone</u>	<u>Address</u>
<u>Specialists</u>	<u>Area of Concern</u>	<u>Organization</u>	<u>Phone/Address</u>
<u>Allergies to Medications</u>	<u>Health /Disability information</u>	<u>Special needs, Equipment and supplies</u>	<u>Other information</u>

Note: Keep on hand at least seven days of vital medications and supplies. Check with your doctor on long term storage or if you use more than one medication

Important Family Information

Insurance/ Other

Company	Type of Policy	Policy #	Coverage Period	Phone #

Family /Friends/ Neighbors

Name	Address	Home #	Work #

****Note: Identify two neighbors and agree to check on each other.*

Household Information

Home Address: _____

Phone 1: _____

Phone 2: _____

E-Mail: _____

Financial Account Information (Banks, Credit Union, Retirement Accounts)

Name of Institution _____

Name of Account holder _____

Account Number _____

Name of Institution _____

Name of Account holder _____

Account Number _____

Name of Institution _____

Name of Account holder _____

Account Number _____

Car Information

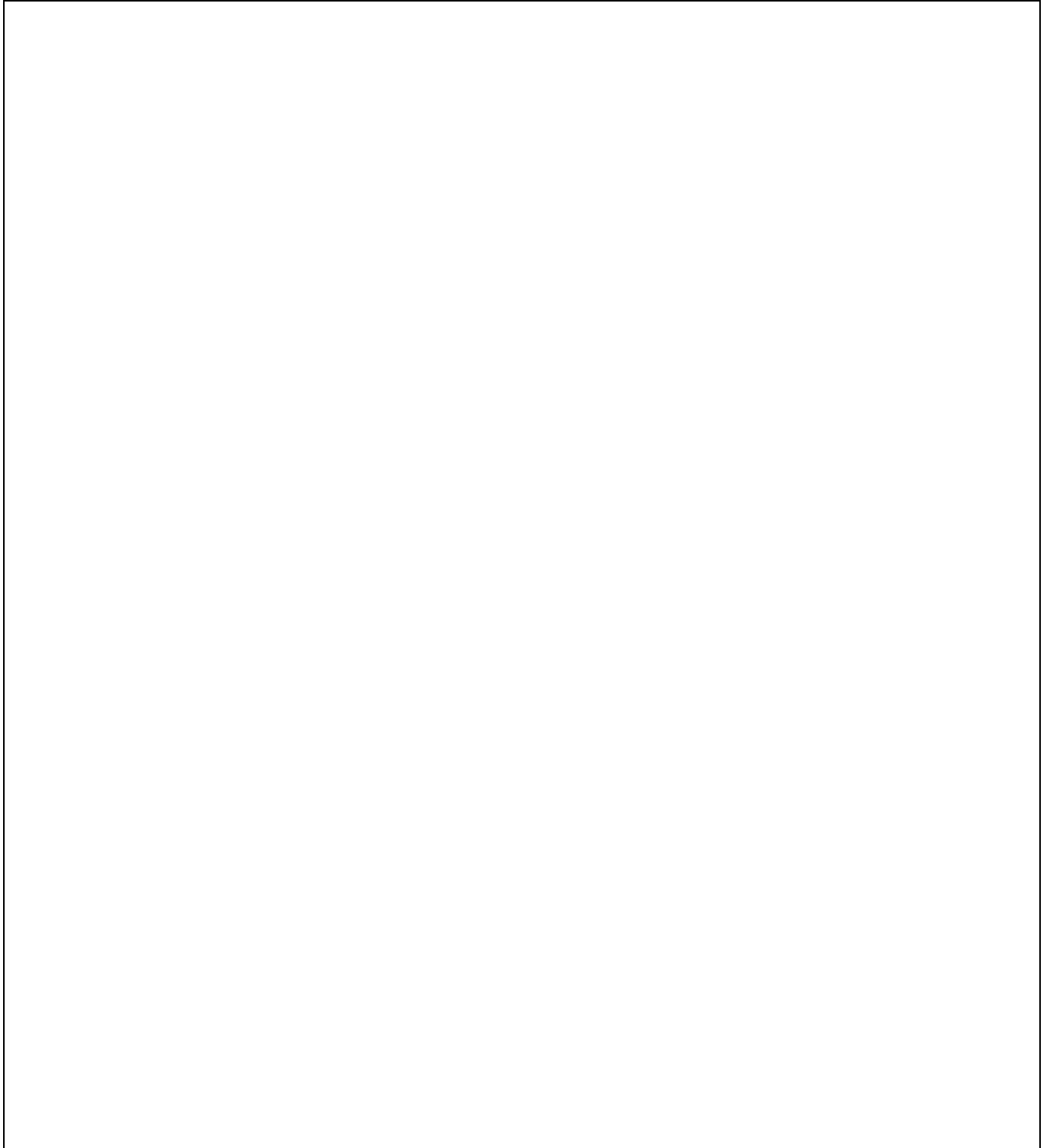
Car 1 Make: _____ Model: _____ Year: _____ License: _____

Car 2 Make: _____ Model: _____ Year: _____ License: _____

Car 3 Make: _____ Model: _____ Year: _____ License: _____

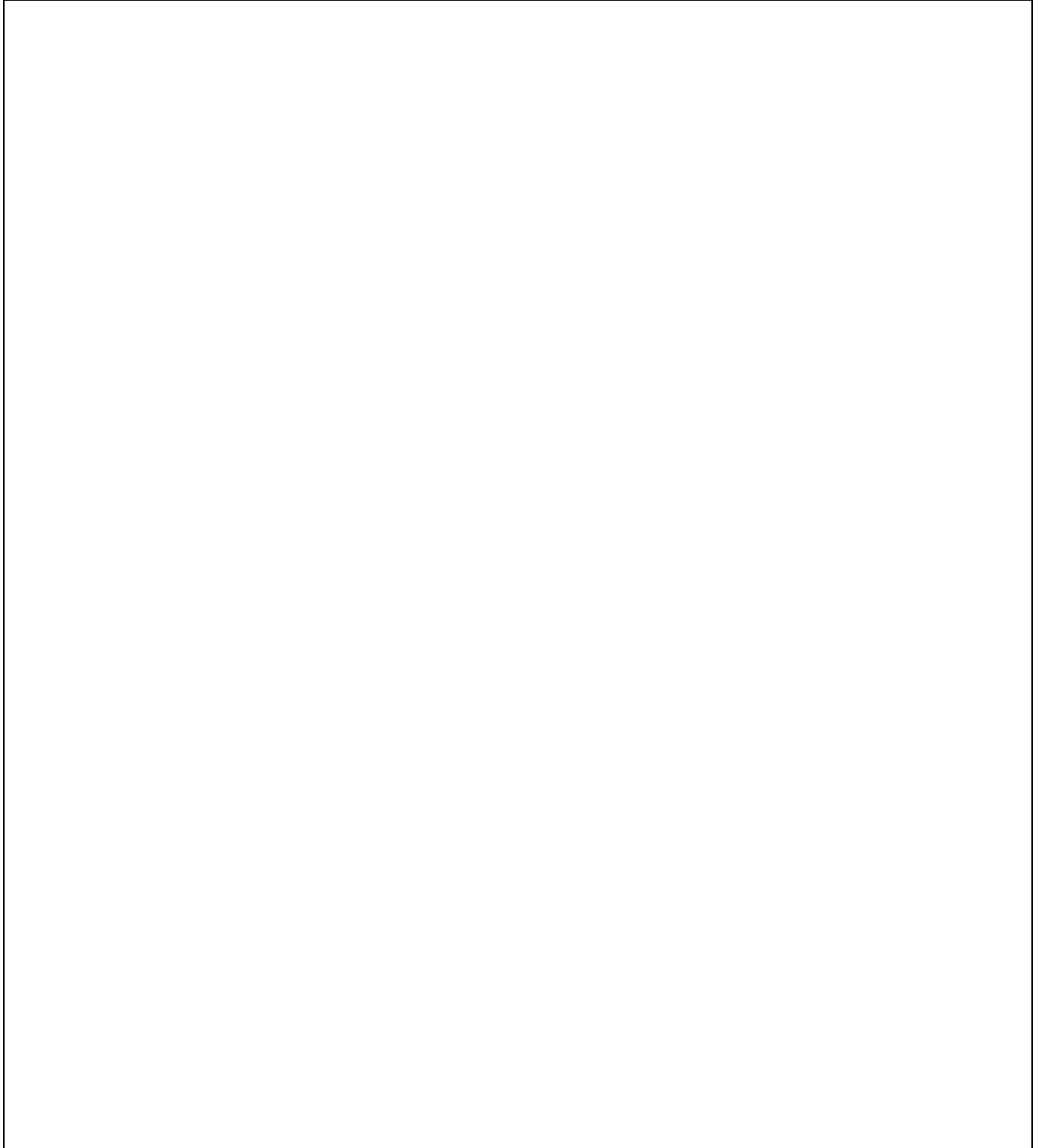
Home Layout/Diagram

Draw a layout of your home. Make sure to include locations of **utility shutoffs** and **safety equipment** such as fire extinguishers and disaster supplies.

A large, empty rectangular box with a thin black border, intended for drawing a home layout diagram. The box is currently blank.

Home Evacuation Routes

Draw out an evacuation route within your home. Make sure to include **all exits**.

A large, empty rectangular box with a thin black border, intended for drawing an evacuation route. The box is currently blank.

Utility Control

Electricity:

1. In the event that you need to turn off the electricity in your house, go to the breaker box and do the following:
2. Turn off small breakers one by one.
3. Flip the "main" breaker last.
4. To reenergize your home, reverse the steps above.

Water:

1. In the event you need to shut water off inside your home, find the main water valve and turn it to your right (clockwise).
2. To open the flow of water back into the house, turn it to your left (counter clockwise).

Gas: **IMPORTANT**-Only turn off your gas at the meter if you smell gas!

1. To turn off natural gas in your house, take a wrench and tighten it on to the quarter turn valve that is on the pipe that feeds into the gas meter.
2. Turn it one quarter turn to make the indicator parallel to the ground.
3. In most locations, once you do this you cannot turn the gas back on to the house without the utility company.

Propane:

1. If you live in an area that uses outdoor propane or LPG you will find this outside the home.
 2. Open the top of the tank and you will see either a regular turn knob or a quarter turn valve.
 3. Turn the knob to your right (clockwise) to shut off the flow of propane into your house. For quarter turn valve see above.
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