

Emergency Phone Numbers

Signup for Stevens County emergency alerts and weather:

Go to www.stevenscountywa.gov; at the top of the screen select Government; now select Emergency Services; then select Resources on the left; now select Hyper-reach sign-up and complete the form.

To review the Stevens County Emergency Plan (CEMP & HMP):

Go to www.stevenscountywa.gov; at the top of the screen select Government; now select Emergency Services; then select Resources on the left; now select CEMP & HMP.

Signup for Outage Alerts from Avista: myavista.com/sign-in

Avista	1-800-227-9187
City of Colville	
City Clerk	684-5094
Water/Sewer	684-2244
Emergency	911
Fire Dept/Fire District	911 The dispatcher will route your call to the appropriate Fire Dept or Fire District. If you don't live within city limits or a fire district, they may not respond to your call. <u>Join your local Fire District.</u>
Stevens County Sheriff	911
Business office	684-5296
After Hours Only	684-2555
Washington State Patrol	911
Colville Office	684-7431

Medical Facilities:

Colville Community Health Center, 358 North Main, Colville	684-1440
Heartland Medicine Colville Clinic, 250 South Main, Colville	684-7925
Providence Mount Carmel Hospital, 982 East Columbia, Colville	685-5100
Providence Northeast Washington Medical Group, 1200 E. Columbia, Colville	684-3701

Ministering Priesthood (Pastor): _____

Family Members: _____

Personal Family Evacuation Plan

Practice with your family

The following suggestions are from FEMA and others with experience:

- If you are asked to evacuate, please do so as quickly as possible.
- Wear protective clothing and sturdy shoes, even in summer.
- Take your 72-Hour Emergency Kit, your Grab and Go container, medications for at least 72 hours, cell phone charger and items listed below. Be prepared to be gone longer than you might think. Once you leave, you may not be allowed to return home.
- Put your pets on a leash or in a carrier and take them with you, if possible. However, most shelters will not accept pets. Some animal hospitals may be willing to board your pets. If you take them with you, be sure to take their food, water and other items they will need.
- Lock all doors and windows. Be sure that all appliances, large and small, are turned off, and that candles are out.
- Leave a note on your front door where you have gone and who is with you.
- Check in with your ministering Priesthood.
- Follow travel routes recommended by local authorities to reach evacuation destination.
- Do not return home until local authorities say that it is safe to do so. You may be given a few minutes to gather some extra things.

Plan ahead:

In case your home is destroyed and/or you are unable to return, identify items that are **irreplaceable** (journals, family photos, scrapbooks, family heirlooms, family records) and have a plan so you can grab them and take them with you.

Item	Location

Individual Information Summary*

Full Name _____ Male Female

Single Married Widowed Divorced

Father's Name _____

Mother's Name _____

Home Phone # _____ Work # _____ Cell # _____

Date of Birth _____ Place of Birth _____

Hair Color _____ Height _____ Weight _____

Birthmarks, Scars, Tattoos _____

Photo

Driver's License # and State _____

DL Expiration Date _____ Social Security _____

Spouse _____ Date of Birth _____ Marriage Date _____

Children:

Name _____ DOB _____ Name _____ DOB _____

Name _____ DOB _____ Name _____ DOB _____

Name _____ DOB _____ Name _____ DOB _____

Name _____ DOB _____ Name _____ DOB _____

School Attended:

High School _____ City/State _____ Degree/Date _____

College _____ City/State _____ Degree/Date _____

College _____ City/State _____ Degree/Date _____

Other _____ City/State _____ Degree/Date _____

Military Service Branch _____ Serial # _____

Enlistment Date _____ Discharge Date _____ Rank _____

Disability _____

Fraternal, Service, Social, and Union Memberships _____

Employment Information:

Employed By _____ Position _____

Starting Date _____

Extended Family:

Name	Address	Phone

Place the following records in your Grab and Go File (G&G) or Safety Deposit Box (SDB):

- | G&G | SDB | |
|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Adoption Decrees |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Certificates |
| <input type="checkbox"/> | <input type="checkbox"/> | Church Records |
| <input type="checkbox"/> | <input type="checkbox"/> | Concealed Carry Permits |
| <input type="checkbox"/> | <input type="checkbox"/> | Custody Agreements |
| <input type="checkbox"/> | <input type="checkbox"/> | Diplomas |
| <input type="checkbox"/> | <input type="checkbox"/> | Divorce Decree |
| <input type="checkbox"/> | <input type="checkbox"/> | Driver’s Licenses |
| <input type="checkbox"/> | <input type="checkbox"/> | Marriage Certificate |
| <input type="checkbox"/> | <input type="checkbox"/> | Military Discharge Form |
| <input type="checkbox"/> | <input type="checkbox"/> | Naturalization Records |
| <input type="checkbox"/> | <input type="checkbox"/> | Passport Numbers |
| <input type="checkbox"/> | <input type="checkbox"/> | Resume/Employment Information |
| <input type="checkbox"/> | <input type="checkbox"/> | Retirement |
| <input type="checkbox"/> | <input type="checkbox"/> | Social Security Cards |

*Complete Individual Information form for each member of the family.

Medical Information Summary*

Individual _____ Birthdate _____ Male Female
 Doctor _____ Phone # _____
 Doctor _____ Phone # _____
 Doctor _____ Phone # _____
 Dentist _____ Phone # _____

Medical Conditions:

Vaccination Record:

Immunization	Date Given	Expiration

Medications/Supplements (including over the counter):

Medication Name	Reason for Med	Amount/How Often	Doctor	Pharmacy

Childhood Diseases:

Disease	Date

Allergies:

Type	Doctor	Medication

Surgeries:

Date	Type	Doctor	Hospital

Medical Tests and Results:

Date	Type	Doctor	Results

*Complete Medical Information form for each member of the family.

CONSENT TO TREAT MINOR CHILDREN *

I, _____, parent or legal guardian of _____, born the ___ day of _____, 20___ do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my child while said child is under the care of _____ of _____, City of _____ State of _____ and I am not reasonably available by telephone to give consent.

This authorization is effective from the ___ day of _____, 20___ to ___ day of _____, 20___

Signature of Parent or Legal Guardian

Date

Witness Signature

Witness Name (please print)

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address _____

Father's Telephone: _____ Mother's Telephone: _____

Last Tetanus: _____

Allergies to drugs or foods: _____

Special Medications, Blood Type or Pertinent Information: _____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy # _____

Preferred Hospital: _____

*Complete one for each minor child

Financial Records Summary

Assets

Checking Accounts:

BANK NAME:	Account #:	Routing #:
Phone #:	URL:	
User Name:	Password:	
BANK NAME:	Account #:	Routing #:
Phone #:	URL:	
User Name:	Password:	
BANK NAME:	Account #:	Routing #:
Phone #:	URL:	
User Name:	Password:	

Savings Accounts:

BANK NAME:	Account #:	Routing #:
Phone #:	URL:	
User Name:	Password:	
BANK NAME:	Account #:	Routing #:
Phone #:	URL:	
User Name:	Password:	
BANK NAME:	Account #:	Routing #:
Phone #:	URL:	
User Name:	Password:	

Investment/Retirement Accounts:

FIRM NAME:	Account #:
Phone #:	URL:
User Name:	Password:
FIRM NAME:	Account #:
Phone #:	URL:
User Name:	Password:
FIRM NAME:	Account #:
Phone #:	URL:
User Name:	Password:
FIRM NAME:	Account #:
Phone #:	URL:
User Name:	Password:
FIRM NAME:	Account #:
Phone #:	URL:
User Name:	Password:

Liabilities

Credit Cards:

Name	Number	Expiration	CVV	Phone

Loans/Mortgages:

ITEM (home, car, etc.):	Company:	Phone #
Loan #	Monthly Payment:	Due Date:
URL:	User Name:	Password:
ITEM (home, car, etc.):	Company:	Phone #
Loan #	Monthly Payment:	Due Date:
URL:	User Name:	Password:
ITEM (home, car, etc.):	Company:	Phone #
Loan #	Monthly Payment:	Due Date:
URL:	User Name:	Password:
ITEM (home, car, etc.):	Company:	Phone #
Loan #	Monthly Payment:	Due Date:
URL:	User Name:	Password:

Regular Monthly Payments:

Item	Company Name	Phone #	Payment Method	Amount
Gas/Electricity				
Water				
Garbage				
House Phone				
Cell Phone				
Satellite/Cable				
Internet Service				
Health Care				
Insurance				
Alarm System				
Newspapers, etc.				
Yard Care				

Regular Annual Payments:

Item	Company Name	Phone #	Payment Method	Amount
Property Taxes				
Income Tax				
Home/Rental Ins				
Vehicle Ins				

Place the following records in your Grab and Go File (G&G) or Safety Deposit Box (SDB):

- | G&G | SDB | |
|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Annual Budget |
| <input type="checkbox"/> | <input type="checkbox"/> | Blank Checks (or other location) |
| <input type="checkbox"/> | <input type="checkbox"/> | Cash in small bills |
| <input type="checkbox"/> | <input type="checkbox"/> | Contracts |
| <input type="checkbox"/> | <input type="checkbox"/> | Income tax records, previous year |
| <input type="checkbox"/> | <input type="checkbox"/> | Safe deposit box key |

Insurance Records Summary

Life Insurance:

Insured Name	Insurance Company	Policy Number	Phone Number

Home Owner's or Renter's Insurance:

Insurance Company	Account Number	Policy Number	Phone Number

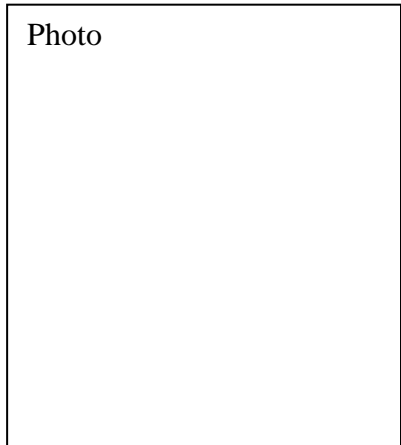
Vehicle Insurance:

<u>Insurance Co:</u>		<u>Policy #</u>	<u>Phone #</u>
Vehicle Name	Year	VIN #	License #

Health Insurance:

<u>Insurer:</u>		<u>Acct #</u>	<u>Phone #</u>
Family Member	ID#	Doctor	Doctor's Phone #

Pet Information Summary*



Name _____

Breed _____

License # _____

Vaccination Record:

Vaccinations	Date	Expires

Medical Information – Visits to Vet, Surgeries, Hospitalizations, Tests, etc.:

Date	Follow up	What

Pet Food/Treats:

Brand	Amount	When

*Complete this form for each pet.