

Special Needs Registry Form

Name: _____

Physical Address: _____

Mailing Address: _____

Phone Number: _____ TTD/TTY: _____

Date Of Birth: _____ Age: _____

Physician Name: _____

Phone: _____

Home Health Care Provider: _____

Phone: _____

Where do you plan to stay during a evacuation?

Home Will you be alone? yes no

With Friends/Family

Emergency shelter Can you get to an evacuation shelter? yes no

If no, check the appropriate transportation needed:

standard vehicle (car, van)

wheelchair equipped

ambulance

Will a caregiver accompany you to the shelter? yes no

Other Arrangements: _____

Do you have a generator? yes no Have you made arrangements for you pets? yes no

Please check all special needs you may have:

legally blind

deaf

terminally ill

contagious disease

bedridden

ambulatory with assistance (walker, cane, wheelchair, etc)

dialysis

IV fluids

insulin

feeding tube

unstable Gran Mal seizures

medically dependent on electricity

equipment: _____

catheter (other than urinary)

severe respiratory illness

oxygen tank # of hours/day _____

do you have a portable tank? yes no

severe mental retardation

severe mental illness

end-stage Alzheimer's

chronic incontinence

advanced senile dementia

require complex dressing changes

moderate/severe symptomatic HIV/AIDS

Additional Information: _____

I certify that the above information is correct to the best of my knowledge. I understand that I am responsible for any expenses associated with medical evaluation and shelter at a hospital, medical facility or nursing home as well as medical transportation. I grant permission to medical providers, transportation agencies and any others to provide care and disclose any information necessary to respond to my emergency needs. I also give local law enforcement permission to enter my home in case of an emergency.

Signature

Date