PAMLICO COUNTY SENIOR SERVICES SPECIAL NEEDS REGISTRATION FORM

Date of Application

Personal Information				
Last Name	First Name	Middle Initial	Date of Birth	Sex ☐Male ☐Female
Address (include city, state and zip code)			Home Phone	Cellular Phone
Email			TTY/Video Phone	Alternate Phone

Living Situation	Residence Type	Race/Ethic Group	Language
☐Alone	☐Private Home	☐African American ☐Asian/Pacific Islander	☐Arabic ☐French ☐Korean
☐With Spouse	☐Apt./Condo	☐Caucasian ☐American Indian	☐Chinese ☐German ☐Russian
☐Other	☐Mobile Home	☐Hispanic	☐English ☐Italian ☐Spanish
☐Vietnamese			

Emergency Contacts				
Primary Emergency Contact	Relationship	Home Phone	Work Phone	Cellular Phone
Address (include city, state and zip code)			Email Address	
Secondary Emergency Contact	Relationship	Home Phone	Work Phone	Cellular Phone
Address (include city, state and zip code)			Email Address	

Medical Information

☐Requires 24-hr Care

Requires life-Sustaining Equipment

☐Oxygen ☐Ventilator ☐Feeding Pump □Dialysis
☐Suction ☐Nebulizer ☐Other(Describe below)

Requires Life-Sustaining Medication

☐Cardiac ☐Respiratory ☐Diabetes ☐Other(Describe below)

Mobility Impairments

☐Bedridden ☐Wheelchair ☐Walker ☐Cane

Communication Impairments

☐Speech Impaired ☐Hard of Hearing
☐Deaf ☐Forgetful

Sight Impairment

☐Blind ☐Other(Describe below)
☐Cardiac History(Describe below)
☐Respiratory History(Describe below)

Dependencies	Medications
Physical Condition	Allergies
Medical Conditions	Other Medical Notes

Medical Providers			
Oxygen Provider	Phone	Home Health Agency	Phone
Primary Physician	Phone	Pharmacy	Phone

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MY PERSONAL DISASTER PLAN

□ I will have a caregiver. Caregiver Name _____

Relationship _____ Phone Number _____

□ I will evacuate/shelter with family/friend. Family/Friend Name _____

Relationship _____ Phone Number _____

Address _____

□ My transportation will be provided by _____

□ I will have all necessary medications and equipment.

□ I will have a list of current medications from my pharmacist.

□ I will have a disaster supplies kit.

MY PET'S DISASTER PLAN

Do you have a pet? □Yes □No If yes, list Type, Size/Weight _____

My Pet's Disaster Plan _____

Do you have a service animal? □ Yes □ No

When bringing a service animal to a shelter, please have identification indicating your need for the animal.

Information Release

I certify that the above information is correct. I hereby grant permission to Pamlico County Department of Emergency Management and Pamlico County Senior Services to use this information for the following purposes ONLY: (1) to include my name/information in the County Special Needs Registry; and/or (2) to give to emergency response agencies for assistance with evacuation or aid in the event of a disaster or emergency. This information is confidential.

SIGNATURE: _____ **DATE:** _____

GAURDIAN: _____

Report prepared by:

Agency/Organization: _____ Phone: _____

Please mail form to:

Pamlico County Senior Services

Special Needs Registry

P.O. Box 184

Alliance NC 28529

For Office Use Only:

Date of Registration _____

****It is your responsibility to verify your contact information with Pamlico County Senior Services at least annually. If we are unable to reach you, you will be removed from the Special Needs Registry. ****