

Disaster Preparedness For Those With Special Needs

SPECIAL NEEDS REGISTRATION

LAST: _____ FIRST: _____ SS# _____
DOB: / / SEX: _____
ADDRESS:
STREET NAME: _____ APT: _____
CITY: _____ ZIP: _____ PHONE: _____

I REQUIRE TRANSPORTATION

LIVING SITUATION: ALONE RELATIVE OTHER
 SINGLE FAMILY RESIDENCE MOBILE HOME
 APT/CONDO, COMPLEX NAME: _____
 CARE TAKER HOSPICE HOME HEALTH
 DO YOU HAVE A PET? Arrangements for pet completed

SPECIAL NEED (CHECK ALL THAT APPLY)

<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Diabetes/insulin dependant
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Memory impaired	<input type="checkbox"/> Mental health impaired
<input type="checkbox"/> Sight impaired	<input type="checkbox"/> Service dog
<input type="checkbox"/> Speech impaired	<input type="checkbox"/> Electric dependent: Reason _____
<input type="checkbox"/> Hearing impaired	<input type="checkbox"/> Walker, cane
<input type="checkbox"/> Breathing treatment	<input type="checkbox"/> Wheelchair bound
<input type="checkbox"/> Bedridden	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Oxygen (lpm _____)	<input type="checkbox"/> Geri chair
<input type="checkbox"/> Feeding tube	<input type="checkbox"/> Ventilator
<input type="checkbox"/> Other _____	
<input type="checkbox"/> None	

Emergency Contacts

NAME: _____ PHONE: _____
NAME: _____ PHONE: _____

Prearranged: Hospital Nursing Home Assisted Living Facility

NAME: _____ PHONE: _____
Doctor's name: _____ PHONE: _____

By signing this form I give my authorization for the medical information contained herein to be released to the County Health Department, Emergency Management, local fire district and receiving facilities for the purpose of evaluating my needs and providing emergency transportation and sheltering. The information contained here will be kept confidential.

Signature

Date

Official use only

Transport to: General Shelter Special Needs Shelter Other _____

Register for Special Needs Shelter Only

Type of Transport: Own vehicle Van/Bus Wheelchair only Stretcher Ambulance

Fire Dist: _____ Grid: _____ Evac Level: _____ Shelter Code: _____ Shelter Name: _____

Comments: _____

Mail to or Drop off at: Southampton Township, Attn: Edward G. Snow, 5 Retreat Road, Southampton, NJ 08088