Disaster Preparedness For Those With Functional Needs

FUNCTIONAL NEEDS REGISTRATION

LAST: _____ FIRST: _____

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)

☐Kidney disease
☐High blood pressure
☐Dialysis
☐Cancer
☐Memory impaired
☐Sight impaired
☐Speech impaired
☐Hearing impaired
☐Breathing treatment
☐Bedridden
☐Oxygen (lpm_____)
☐Feeding tube
☐Other _____
☐None

☐Diabetes/insulin dependent
☐Heart disease
☐Stroke
☐Emphysema
☐Mental health impaired
☐Service dog
☐Electric dependent: Reason
☐Walker, cane
☐Wheelchair bound
☐Incontinence
☐Geri chair
☐Ventilator

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: Office of Emergency Management, 5 Retreat Road, Southampton, NJ 08088