SPECIAL NEEDS REGISTRATION

Name:_____
Street Address:_____
City:_____

What type of telephone service do you have (Check all that Apply):

☐ Cordless Phone	☐ Cell Phone	☐ Landline Phone	☐ None
_____	_____	_____	
Number	Number	Number	

Emergency Contact (Name/Phone#)

_____

_____

Please list equipment or medications that must be Transported with you. Is electricity required?

_____

_____

_____

What are your transportation needs in the event of a Disaster? i.e., special vehicle, ambulance, etc.

_____

_____

_____

Medical Conditions:

□ Anxiety/Depression	□ Visually or Hearing Impaired	□ Cancer or Chemo	□ Cognitive Impairment
□ Diabetes	□ Feeding Pump	□ Mental Disorder	□ Open Wounds
□ Dialysis	□ Pulmonary Disorder	□ Speech Impairment	□ Suction Required
□ Para or Quadriplegic	□ Ventilator	□ Other:_____	
□ None			

Oxygen Concentrator: Liters_____ Equipment_____ Bottles_____
Provider_____

Other Forms of Mobility Assistance Used:

□ Walker □ Wheelchair □ Cane □ None

Home Care Status

□ I take care of myself at home □ I have outside nursing help at home □ I have a live-in care provider at home

Home Care Provider Contact Information (If Applicable)

_____

_____ _____

Signed Date

Do you have any pets or a service animal? □ Yes □ No

If Yes, please describe

_____

Please include any other comments or remarks:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for participating!