

# SPECIAL NEEDS REGISTRY FORM

NAME: \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

PHYSICAL ADDRESS: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

DOB: \_\_\_\_\_ SEX: M \_\_\_ F \_\_\_ PHONE: ( ) \_\_\_\_\_

EMERGENCY CONTACT PERSON: \_\_\_\_\_

PHONE - HOME: ( ) \_\_\_\_\_ WORK: ( ) \_\_\_\_\_ CELL: ( ) \_\_\_\_\_

PRIMARY LANGUAGE: \_\_\_\_\_

PRIMARY PHYSICIAN: \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

ARE YOU CURRENTLY RECEIVING HOME HEALTH CARE? YES \_\_\_ NO \_\_\_

IF YES, NAME OF AGENCY: \_\_\_\_\_

NAME AND PHONE NUMBER OF THE ONE REQUIRED CAREGIVER THAT WILL BE RESPONSIBLE FOR YOUR CARE IN THE SHELTER:

NAME: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_

PHARMACY: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

- CAN YOU WALK? YES \_\_\_ NO \_\_\_
- CAN YOU SIT UP OR RIDE A BUS? YES \_\_\_ NO \_\_\_
- DO YOU NEED A WHEELCHAIR LIFT? YES \_\_\_ NO \_\_\_
- DO YOU NEED ASSISTANCE GETTING IN AND OUT OF A WHEELCHAIR? YES \_\_\_ NO \_\_\_
- DO YOU REQUIRE AN AMBULANCE FOR TRANSPORTATION? YES \_\_\_ NO \_\_\_  
(IF YES, YOU WILL BE CONTACTED BY EMERGENCY MEDICAL SERVICES PRIOR TO THE EVENT)
- DO YOU REQUIRE MEDICAL EQUIPMENT? YES \_\_\_ NO \_\_\_

CHECK ALL THAT APPLY:

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> OXYGEN                 | <input type="checkbox"/> WOUND VAC    | <input type="checkbox"/> BEDSIDE COMMODE   |
| <input type="checkbox"/> IV/CENTRAL LINES/PORTS | <input type="checkbox"/> CATHETER     | <input type="checkbox"/> WHEELCHAIR        |
| <input type="checkbox"/> SUCTION                | <input type="checkbox"/> FEEDING TUBE | <input type="checkbox"/> FEEDING TUBE/PUMP |
| <input type="checkbox"/> COLOSTOMY              |                                       |  |

DO YOU REQUIRE MEDICAL EQUIPMENT (CONTINUED)....?

- \_\_\_\_\_ WALKER
- \_\_\_\_\_ VENTILATOR (A MACHINE THAT BREATHES FOR YOU)
- \_\_\_\_\_ NEBULIZER (A MACHINE THAT GIVES YOU MEDICATION IN A MIST)
- \_\_\_\_\_ WOUND CARE SUPPLIES
- \_\_\_\_\_ CPAP
- \_\_\_\_\_ PRESSURE MATTRESS/CUSHION
- \_\_\_\_\_ DIALYSIS:            PERITONEAL \_\_\_\_\_    HEMO \_\_\_\_\_

CHECK CONDITIONS THAT YOU HAVE:

- DIABETES?    YES \_\_\_\_\_    NO \_\_\_\_\_  
IF YES, DO YOU REQUIRE INSULIN? YES \_\_\_\_\_    NO \_\_\_\_\_
  
- SIGHT IMPAIRED?    YES \_\_\_\_\_    NO \_\_\_\_\_  
IF YES, DO YOU HAVE AN EYE DOG? YES \_\_\_\_\_    NO \_\_\_\_\_
  
- EPILEPSY?        YES \_\_\_\_\_    NO \_\_\_\_\_
  
- CONTAGIOUS DISEASE? YES \_\_\_\_\_    NO \_\_\_\_\_  
IF YES, PLEASE SPECIFY \_\_\_\_\_
  
- MENTAL ILLNESS?  
IF YES, PLEASE SPECIFY \_\_\_\_\_
  
- SPEECH OR HEARING IMPAIRED? YES \_\_\_\_\_    NO \_\_\_\_\_
  
- MEMORY IMPAIRMENT? YES \_\_\_\_\_    NO \_\_\_\_\_

OTHER CONDITIONS \_\_\_\_\_  
\_\_\_\_\_

The information contained herein is true and correct to the best of my knowledge. I understand that assistance will be provided only for the duration of the emergency and that alternative arrangements should be made in advance in the event I am not able to return to my home. I also understand that I will be responsible for any charges and costs associated with hospital or other medical facility care or medical transportation. I grant permission to medical providers and transportation agencies and others as necessary to provide care and disclose any information to respond to my needs. I also grant permission to emergency personnel and law enforcement to enter my home following an emergency if deemed necessary by proper authorities. I understand this registration is voluntary and hereby request registration in the Special Needs Program. I understand that all information given will be held in strict confidence and will be used for emergencies only.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date of Signature

**Please return to the following:      Franklin County Office of Emergency Services  
8146 NC 56 Highway  
Louisburg, NC 27549**