

SPECIAL NEEDS REGISTRATION FORM

LAST NAME _____ FIRST _____ MIDDLE _____

SSN _____ (optional) SEX _____ LANGUAGE _____ RACE _____

DATE OF BIRTH ____/____/____ AGE ____ PHONE (____) _____ TDD? Yes No

ADDRESS _____

CITY _____ STATE _____ ZIP _____ TODAY'S DATE _____

EMERGENCY CONTACT DATA:

Name _____ Relationship _____

Address _____

Work Phone _____ Home Phone _____ Cell Phone _____

OVER ALL FUNCTIONAL AND MEDICAL STATUS

- | | | | | | |
|---------------------|--------------------------|------------------------------|--------------------------|-------------------------------|--------------------------|
| ADL Impairments | <input type="checkbox"/> | Functional Status _____ | Oxygen | <input type="checkbox"/> | |
| Bedridden | <input type="checkbox"/> | Hearing Impaired | <input type="checkbox"/> | Requires 24 Hr. Care | <input type="checkbox"/> |
| Blind | <input type="checkbox"/> | Hypertension/Stroke | <input type="checkbox"/> | Respirator | <input type="checkbox"/> |
| Cane | <input type="checkbox"/> | IADL Impairments | <input type="checkbox"/> | Self-Declared Disability | <input type="checkbox"/> |
| Client HDM | <input type="checkbox"/> | Insulin Dependent | <input type="checkbox"/> | Service Animal | <input type="checkbox"/> |
| Client is Caregiver | <input type="checkbox"/> | Limited Vision | <input type="checkbox"/> | Service Relieves a Care Giver | <input type="checkbox"/> |
| Client is Oriented | <input type="checkbox"/> | Lives Alone | <input type="checkbox"/> | Sight Impaired | <input type="checkbox"/> |
| Deaf | <input type="checkbox"/> | Medical Electricity Required | <input type="checkbox"/> | Special Eligibility | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Mobile Home | <input type="checkbox"/> | Special Needs Client | <input type="checkbox"/> |
| Dialysis | <input type="checkbox"/> | Mobility Impaired | <input type="checkbox"/> | Speech Impaired | <input type="checkbox"/> |
| Economically Needy | <input type="checkbox"/> | Monitor | <input type="checkbox"/> | Walker | <input type="checkbox"/> |
| Enhanced Care | <input type="checkbox"/> | Nutritional Scale | <input type="checkbox"/> | Wheel Chair | <input type="checkbox"/> |
| Ensure | <input type="checkbox"/> | Other Electricity Required | <input type="checkbox"/> | Willing to be Transported | <input type="checkbox"/> |

MEDICATIONS: _____

MEDICAL CONDITIONS: _____

PHYSICAL CONDITIONS: _____

ALLERGIES: _____

DEPENDENCIES (medical equipment): _____

OXYGEN PROVIDER: _____ PHONE: _____

HOME HEALTH AGENCY: _____ PHONE: _____

SPECIAL NEEDS REGISTRATION FORM

Primary Physician: _____
First Name Last Name Phone

Pharmacy: _____
Name Phone

In the event of an emergency, I prefer to: (Check)

Stay at home.

Do you have all necessary medications and equipment? Yes No

Go to a shelter.

Who will be your caretaker?

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.

Stay with family/friends.

Address and Phone:

Other _____

Will you need transportation? Yes No

Information Release

I certify that the above information is correct. I hereby grant permission to New Hanover County Department of Emergency Management and the Department of Aging Retired & Senior Volunteer Program **and volunteers working under the direction of these agencies** 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: _____

GUARDIAN: _____

Report prepared by:

Agency/Organization: _____ Phone: _____

Please mail form to:

New Hanover County
Special Needs Registry
2222 S. College Road
Wilmington, NC 28403

Questions/Comments: (910) 798-6416

For Office Use Only:

RSVP File # _____

Date of Registration _____