

# Medical Special Needs Registry - 2010

Today's Date: \_\_\_\_\_

Do you want this information released to the state's Special Needs Registry?

Yes No

If staffing permits, would you like a home visit from a medical professional to help you prepare your vial of life kit?

Yes No

## **Head of Household:**

Name:

\_\_\_\_\_

(First)

(MI)

(Last)

## **Special Needs Registrant:**

Name:

\_\_\_\_\_

(First)

(MI)

(Last)

Gender: Female Male

Date of Birth: \_\_\_\_\_

Street Address:

\_\_\_\_\_

(Number)

(Street)

(Apt or Building #)

\_\_\_\_\_

(City)

( County)

( Zip Code)

Mailing Address (if different from street address):

\_\_\_\_\_

(Number)

(Street)

(Apt or Building #)

\_\_\_\_\_

(City)

( County)

(Zip Code)

**Residence type:**

(Please Circle)

Single Family Home	Apartment
Duplex	Mobile Home
Condo	Dorm
Other:	

**Questions about the special needs registrant to assist Emergency Management Officials:** (Please circle YES or NO and answers questions in the space provided)

Do you depend on others for routine care?	YES	NO
Do you require assistance with medication administration?	YES	NO
Do you need transportation to evacuate	YES	NO
Is your condition temporary?	YES	NO
• If YES, what is your estimated recovery date?		
Do you have a Vial of Life?	YES	NO
• Would you like a Vial of Life kit mailed to you?	YES	NO
Will a caregiver or family member evacuate with you?	YES	NO
• How many others will be evacuating with you?		
• Do you have a Service Animal?		
• How many pets do you have?		
• How many pet carriers do you have?		

**Please circle all that apply:**

Blind	Confined to hospital bed	Extensive Medical Care
Weigh over 350 pounds	Mental Health Disorder	Mentally Retarded
Deaf	Hearing Impaired	Amputee
Use Oxygen	Cane	Wheelchair
Motorized Wheelchair	Walker	Ventilator
Dialysis	Nebulizer	Blood Sugar Monitor
Life Support Equipment	Medication requiring refrigeration	Medical equipment requiring power

**Phone Numbers:**

Primary: \_\_\_\_\_ Extn: \_\_\_\_\_ (TTY YES/NO)

Secondary: \_\_\_\_\_ Extn: \_\_\_\_\_ (TTY YES/NO)

E-mail: \_\_\_\_\_

**Emergency Contact:**

Name:

\_\_\_\_\_  
(First) (MI) (Last)

Relationship: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Primary Phone # : \_\_\_\_\_ Secondary Phone # : \_\_\_\_\_

**Who will provide update information?** (Please circle)

Special needs registrant

Legal Guardian

Emergency Contact

\_\_\_\_\_  
Signature of Registrant or Legal Guardian

\_\_\_\_\_  
Date

**\*FOR OFFICE USE ONLY\***

Date Received:

Entry Date:

Assigned Level:

Entry By:

Zone :

Type of Transportation:

Comments:

