

SPECIAL MEDICAL NEEDS REGISTRY FORM

NAME:		GENDER: M <input type="checkbox"/> F <input type="checkbox"/> AGE: _____			
ADDRESS (Where you live) →		DIRECTIONS:			
TYPE DWELLING (check one) →	Ground floor <input type="checkbox"/> Upper level <input type="checkbox"/> Trailer <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/>				
MAILING ADDRESS (If different from above)	TELEPHONE:		TTD/TTY:		
EMERGENCY CONTACT PERSON		E-MAIL:			
ADDRESS	RELATIONSHIP:		PHONE:		
CAREGIVER	ALTERNATE PHONE:		PHONE:		
PRIMARY CARE PHYSICIAN'S NAME: CLINIC OR PRACTICE ADDRESS:					
		PHONE:			
		FAX:			
SPECIAL NEEDS (check all that apply)	Dialysis <input type="checkbox"/> _____ # of times per week Refrigeration of meds Y <input type="checkbox"/> N <input type="checkbox"/> Wheelchair user <input type="checkbox"/> Bedridden <input type="checkbox"/> Ambulatory needs? Y <input type="checkbox"/> N <input type="checkbox"/> Have a Catheter <input type="checkbox"/> Feeding tube <input type="checkbox"/> Oxygen <input type="checkbox"/> Spare tank? Y <input type="checkbox"/> N <input type="checkbox"/> Interpreter? Language <input type="checkbox"/> Hearing <input type="checkbox"/> Walker <input type="checkbox"/> Respiratory units _____ Elec for medical equip <input type="checkbox"/> (circle one) 110V or 220V				
Any additional information on special needs					
Do you have a service dog? (check one)	Y <input type="checkbox"/> N <input type="checkbox"/>	Service animals are the only pets allowed at the shelter. What arrangements do you have for other pets?			
In case of disaster, I will... (check all that apply)	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> Stay home if possible <input type="checkbox"/> Stay with family or others <input type="checkbox"/> Have transportation <input type="checkbox"/> Already have a written family disaster plan attached <input type="checkbox"/> </td> <td style="width: 50%; border: none;"> Go to special needs shelter <input type="checkbox"/> Need to go to hospital or ER <input type="checkbox"/> Need ambulance transportation <input type="checkbox"/> Require lift equipped van <input type="checkbox"/> </td> </tr> </table>			Stay home if possible <input type="checkbox"/> Stay with family or others <input type="checkbox"/> Have transportation <input type="checkbox"/> Already have a written family disaster plan attached <input type="checkbox"/>	Go to special needs shelter <input type="checkbox"/> Need to go to hospital or ER <input type="checkbox"/> Need ambulance transportation <input type="checkbox"/> Require lift equipped van <input type="checkbox"/>
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I certify that the above information is correct to the best of my knowledge. I understand that I am responsible for all expenses associated with medical evacuation and shelter at a hospital. I hereby grant permission to the Cumberland County Department of Social Services, Cumberland County Emergency Services, and special needs shelter staff to release the information on this form to other emergency response or human service professionals or officials as needed during times of disaster. I also give local law enforcement permission to enter my home in case of emergency. I understand I am providing this information voluntarily.					
Signature of applicant _____		Date _____			
For person completing form if other than the special needs applicant:					
Name _____		Relationship to applicant _____			
Phone number where you can be reached _____					
Signature _____		Date _____			
Please return form to: Cumberland County Department of Social Services ATTN: District # 002 PO Box 2429 Fayetteville, NC 28302					