

New Hanover County Special Needs Registration Form

Date of Application

Personal Information

Last Name		First Name		Middle Initial	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address (include city, state and zip code)					Home Phone	Cellular Phone	
Email			Brunswick EPZ <input type="checkbox"/> Yes <input type="checkbox"/> No		TTY/Video Phone	Alternate Phone	
			<input type="checkbox"/> Zone K <input type="checkbox"/> Zone L				
Living Situation <input type="checkbox"/> Alone <input type="checkbox"/> With Spouse <input type="checkbox"/> Other		Residence Type <input type="checkbox"/> Private Home <input type="checkbox"/> Apt./Condo <input type="checkbox"/> Mobile Home		Race/Ethnic Group <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian		Language <input type="checkbox"/> Arabic <input type="checkbox"/> Chinese <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Italian <input type="checkbox"/> Korean <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Tagalong <input type="checkbox"/> Vietnamese	

Emergency Contacts

Primary Emergency Contact		Relationship	Home Phone	Work Phone	Cellular Phone
Address (include city, state and zip code)			Email Address		
Secondary Emergency Contact		Relationship	Home Phone	Work Phone	Cellular Phone
Address (include city, state and zip code)			Email Address		

Medical Information

<input type="checkbox"/> Requires 24-hr Care Requires Life-Sustaining Equipment <input type="checkbox"/> Oxygen <input type="checkbox"/> Ventilator <input type="checkbox"/> Feeding Pump <input type="checkbox"/> Dialysis <input type="checkbox"/> Suction <input type="checkbox"/> Nebulizer <input type="checkbox"/> Other (Describe Below) Requires Life-sustaining Medication <input type="checkbox"/> Cardiac <input type="checkbox"/> Respiratory <input type="checkbox"/> Diabetes <input type="checkbox"/> Other (Describe Below) Mobility Impairments <input type="checkbox"/> Bedridden <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Cane	Communication Impairments <input type="checkbox"/> Speech Impaired <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Deaf <input type="checkbox"/> Forgetful Sight Impairments <input type="checkbox"/> Blind <input type="checkbox"/> Other (Describe Below) <input type="checkbox"/> Cardiac History (Describe Below) <input type="checkbox"/> Respiratory History (Describe Below)
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Dependencies	Medications
Physical Conditions	Allergies
Medical Conditions	Other Medical Notes

Medical Providers

Oxygen Provider	Phone	Home Health Agency	Phone
Primary Physician	Phone	Pharmacy	Phone

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Special Needs Registration Form**

MY PERSONAL DISASTER PLAN

- I will have a caregiver. Caregiver Name _____
Relationship _____ Phone Number _____

- I will evacuate/shelter with family/friend. Family/Friend Name _____
Relationship _____ Phone Number _____
Address _____

- My transportation will be provided by _____

- I will have all necessary medications and equipment.
- I will have a list of current medications from my pharmacist.
- I will have a disaster supplies kit.

MY PET'S DISASTER PLAN

Do you have a pet? Yes ___ No___ If yes, list Type, Size/Weight _____

My Pet's Disaster Plan _____

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.

Information Release

I certify that the above information is correct. I hereby grant permission to New Hanover County Department of Emergency Management and the Senior Resource Center 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) 798-6400

For Office Use Only:
RSVP File #
Date of Registration

****It is your responsibility to verify your contact information with the New Hanover County Senior Resource Center at least annually. If we are unable to reach you, you will be removed from the Special Needs Registry. ****

****Citizens utilize the services of the Special Needs Registry & IC3 at their own discretion. The Special Needs Registry, IC3, Health Care Facilities, and Adult Care Homes, acting in good faith, are permitted to waive certain rules in order to provide temporary shelter or services during disasters and emergencies. Temporary sheltering facilities, IC3, and The Special Needs Registry aren't liable for providing care. A personal caregiver is required during the period of temporary placement.****