PERQUIMANS COUNTY VOLUNTARY SPECIAL NEEDS REGISTRATION FORM

LAST NAME_____ **FIRST NAME**_____ **MIDDLE**_____

ADDRESS_____**CITY**_____**STATE** _____ **ZIP**_____

TODAY'S DATE_____**HOME PHONE**_____**EMAIL**_____

CELL PHONE_____**TEXT ONLY**_____**TTY /VIDEO PHONE**_____

SEX _____**AGE** _____ **LANGUAGE** _____**RACE**_____**DATE OF BIRTH**_____

EMERGENCY CONTACT #1_____**RELATIONSHIP**_____

ADDRESS_____**EMAIL** _____

HOME PHONE_____**CELL PHONE**_____**WORK PHONE** _____

EMERGENCY CONTACT #2_____**RELATIONSHIP**_____

ADDRESS_____**EMAIL**_____

HOME PHONE_____**CELL PHONE**_____**WORK PHONE** _____

Select all that apply in this section:

- ❑ Lives Alone
- ❑ Lives in Mobile Home
- ❑ Service Animal_____
- ❑ Pet
- ❑ Requires 24 Hour Care
- ❑ Home Delivered Meals Client
- ❑ Mobility Impaired
  - ❑ Bedridden
  - ❑ Wheelchair
  - ❑ Walker
  - ❑ Cane
- ❑ Medical Electricity Required
  - ❑ Oxygen
  - ❑ Ventilator
  - ❑ Feeding Pump
  - ❑ Dialysis
- ❑ Sight Impaired
  - ❑ Blind
  - ❑ Other_____
- ❑ Communication Impairments
  - ❑ Speech Impaired
  - ❑ Hard of Hearing
  - ❑ Deaf
  - ❑ Language Other Than English
  - ❑ Forgetful
- ❑ Diabetes
- ❑ Insulin Dependent
- ❑ Asthma
  - ❑ Inhaler
  - ❑ CPAP
- ❑ Pacemaker
- ❑ Defibrillator

MEDICAL CONDITIONS:_____

PHYSICAL CONDITIONS:_____

MEDICATIONS:_____

ALLERGIES:_____

DEPENDENCIES (medical equipment):_____

OXYGEN PROVIDER:_____ **PHONE:**_____

HOME HEALTH AGENCY:_____ **PHONE:**_____

PRIMARY PHYSICIAN:_____ **PHONE:**_____

PHARMACY:_____ **PHONE:**_____

OTHER INFO: _____

PERQUIMANS COUNTY VOLUNTARY SPECIAL NEEDS REGISTRATION FORM

MY PERSONAL DISASTER PLAN

Plan for Sheltering at Home

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

Plan for Evacuation

- Go to a shelter
  Caregiver Name______________________________ Phone Number
- Stay with family/friend
  Address ____________________________________ Phone Number
- Transportation Provided by _________________________________

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.)

Do you have a pet? Yes __ No__ If yes, list Type and Size/Weight ___________

My Pet's Disaster Plan ____

____

Information Release

I certify that the above information is correct. I hereby grant permission to Albemarle Regional Health Services, Perquimans County Social Services, Perquimans County Emergency Services and The Albemarle Commission 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; and/or (3) to add my cell phone number to the County's Reverse 911 Communication System. This information is confidential.

SIGNATURE:____DATE:______________________________

GUARDIAN:____

- -

Report prepared by:

Agency/Organization:__________________________________ Phone:_________________ Date:____________

- -

Please mail form to:

Perquimans County Emergency Services

P.O. Box 563

Hertford, NC 27944

If any questions: Email – jnixon@perquimanscountync.gov or Call (252) 426-5646

****It is your responsibility to verify your contact information with Perquimans County Emergency Services at least annually or at any time when information changes. If we are unable to reach you, you will be removed from the Special Needs Registry. ****