

Special Needs Voluntary Registration
After completing this form return to the address on the other side

Name: _____ Date of Birth: _____

Your Street Address: _____

City: _____ Zip: _____ Phone#: _____

Your Mailing Address: _____

Caregiver: _____ Phone: (h) _____ (w) _____

Emergency Contact Person: _____

Phone: (h) _____ (w) _____

Primary Language: _____

TDD/TTY (for hearing impaired) ___ Yes ___ No

Primary Physician: _____ Physician's Phone _____

Home Health Care Provider: _____

Home Health Care Provider Phone #: _____

Pharmacist: _____ Pharmacist Phone#: _____

*What is your primary disaster plan?

___ 1. Stay with family or others:
If so, name address, phone # _____

___ 2. Stay at home; Do you have a generator? _____

___ 3. Evacuate to a shelter (A caregiver must accompany you to the shelter and stay with you.)

*Do you have transportation to a shelter? ___ Yes ___ No

If No, what are your transportation needs? ___ Car ___ Van with lift ___ Ambulance

* Do you need assistance with walking? ___ Walks Unassisted ___ Walks with Assistance

___ Wheelchair ___ Bed Bound

*** Disabilities**

Hearing Impaired Sight Impaired Speech Impaired

Contagious Disease Assistance Dog (Such as guide dog)

Other: _____

***Do you presently live in:** Apartment Home Mobile Home

***Do you have medical equipment that requires Power?** Yes No

***Medical Needs**

Life Support Dialysis _____ (Frequency)

Feeding Tube IV Fluids _____ (Frequency)

Insulin (Self) Suction Unit _____ (Frequency)

Insulin (With assistance) Special Diet (Describe) _____

Ventilator Oxygen _____ Hours per day

Wound Care _____ (frequency) Portable Oxygen Tank

24 Hour Caregiver Concentrator (for oxygen)

Colostomy (Self) Oxygen Provider _____

Colostomy(with assistance) Other: _____

Ileostomy (self) _____

Ileostomy (with assistance) _____

*** Do you have equipment or supplies that you cannot transport?** If yes, please

list: _____

I certify that the above information is correct. I understand that I am responsible for all expense associated with medical evacuation and shelter at a hospital. I hereby authorize Cerro Gordo County Emergency Management to release, use or disclose this information to other emergency response or human services agencies or officials. I also give law enforcement permission to enter my home in case of an emergency.

Signature _____ Date

Return This Form To:

**Cerro Gordo and Franklin County Emergency Management
78 S. Georgia Avenue
Mason City, IA 50401**