Edison Township - Special Needs Registry
Office of Emergency Management
The following is strictly for identification with the minimum data requested from individuals with disabilities and frail elderly who volunteer to register.

Personal/Residency Information

- First Name: _____ Middle Initial: ____
  Last Name: _____
- Sex ☐ Male ☐ Female
- DOB_____ Date Form Completed: _____
- Type of Residence: ☐ Private ☐ Special Needs ☐ Public Housing
- Facility/Residence/Community Name:_____
- Street Address: _____ ***Not a PO Box**
  Address Line 2: _____
  Apartment Building Name and Number: _____
  Floor Level: _____
- Municipality/City: _____
- Phone Number: _____
- Cell Phone: _____
- E-mail Address: _____
- How well do you understand the English language?
  ☐Well ☐Not well ☐ Not well at all
- Primary language spoken: _____
- If Special Needs, Special Needs Residence Type:
  ☐Assisted Living ☐Retirement Community ☐ Senior Housing
  ☐Group Home ☐ Residential Health Care Facility ☐ Other
- How many people including yourself are in your household?
  ☐ Live alone ☐ 1 other person ☐ 2 other persons ☐ 3 other persons
  ☐more than 3 people
- Are you responsible for minor children living with you? ☐ Yes ☐ No
  If yes, how many? _____

Emergency Contact Information

- First Name: _____ Middle Initial: ____
  Last Name: _____
- Street Address: _____ ***Not a PO Box**
  Address Line 2: _____
  City: _____ State: _____ Zip Code: _____
- Phone Number: _____Cell Phone : _____
- Fax Number: _____
- E-mail Address : _____

The following information will further help us prepare for your evacuation

- Do you have pets living with you? ☐ Yes ☐ No
- Do you have a service animal? ☐ Yes ☐ No
- Weight Range ☐ Less than 300 lbs. ☐ 300 lbs. or over
- Are you bed bound? ☐ Yes ☐ No

- You walk with the assistance of :
  ☐ No assistance ☐ Another person ☐ Cane ☐ Crutches ☐ Walker
  ☐Service Animal ☐ Other
- Do you use a Wheelchair or scooter? ☐ Yes ☐ No
  Type: ☐ Manual wheelchair ☐ Motorized wheelchair ☐ Scooter
- Sight Impaired? ☐ No impairment ☐ Need glasses ☐ Blind
- Hearing Impaired? ☐ No impairment ☐ Hearing aid ☐ Deaf
- Check all items that apply :
  ☐ Use Oxygen
  ☐ Use respirator
  ☐ Cognitive Impairment
  ☐ Alzheimer/ dementia
  ☐ Developmental disability
  ☐ Mental Health condition

Evacuation Transportation Requirement

- Do you require transportation? ☐ Yes ☐ No
  If yes:
  Standard transportation ☐ Yes ☐ No
  Can you slide transfer? ☐ Yes ☐ No
  Do you need vehicle with a lift? ☐ Yes ☐ No
  Must be transported by Ambulance? ☐ Yes ☐ No

The following information will be helpful for your possible stay at an Emergency Shelter

- Do you have :
  Personal Emergency Kit? ☐ Yes ☐ No
  Medication list? ☐ Yes ☐ No
  File/Vial of Life? ☐ Yes ☐ No
  Food Allergies? ☐ Yes ☐ No
  If yes, specify _____
  Other Allergies? ☐ Yes ☐ No
  If yes, specify _____
  Dialysis required? ☐ Yes ☐No
  If yes, specify how often _____

This form was filled out by ☐ Self ☐Family Member ☐Other(name)_____

I am submitting this form voluntarily, for the use by emergency personnel, in the event that I should require assistance during an emergency.

_____
Signature

_____
Date