



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:

- | | |
|---|--|
| <input type="checkbox"/> Lives Alone | <input type="checkbox"/> Sight Impaired |
| <input type="checkbox"/> Lives in Mobile Home | <input type="checkbox"/> Blind |
| <input type="checkbox"/> Service Animal _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Pet | <input type="checkbox"/> Communication Impairments |
| <input type="checkbox"/> Requires 24 Hour Care | <input type="checkbox"/> Speech Impaired |
| <input type="checkbox"/> Home Delivered Meals Client | <input type="checkbox"/> Hard of Hearing |
| <input type="checkbox"/> Mobility Impaired | <input type="checkbox"/> Deaf |
| <input type="checkbox"/> Bedridden | <input type="checkbox"/> Language Other Than English |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Forgetful |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Cane | <input type="checkbox"/> Insulin Dependent |
| <input type="checkbox"/> Medical Electricity Required | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Oxygen | <input type="checkbox"/> Inhaler |
| <input type="checkbox"/> Ventilator | <input type="checkbox"/> CPAP |
| <input type="checkbox"/> Feeding Pump | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> 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. ****