

Perquimans County Voluntary Special Needs Registration

Evaluating Special Needs in the event of a disaster

Please print clearly

Name: _____ DOB: / / Gender: M / F

Mailing Address: _____

City: _____ Zip: _____ Phone: _____ Cell: _____

Physical Address: _____

City: _____ Zip: _____ Single Family Mobile Home Apt/ Condo

Directions to home: _____

If married, name of spouse: _____ Is spouse registered? Yes No

Primary Caregiver: _____ Phone: _____ Cell: _____

Home Health Provider: _____ Phone: _____

Hospice Provider: _____ Phone: _____

Special Need:

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> IV Dependent | <input type="checkbox"/> Feeding Tube | <input type="checkbox"/> Ventilator | <input type="checkbox"/> Oxygen |
| <input type="checkbox"/> Sight Impaired | <input type="checkbox"/> Hearing/ Speech Impaired | <input type="checkbox"/> Breathing Treatment | <input type="checkbox"/> Bedridden/ Homebound | <input type="checkbox"/> Electric Dependent |
| <input type="checkbox"/> Wheelchair Bound | <input type="checkbox"/> Wound Care | Other: _____ | | |

Please list/ describe condition:

Emergency Contact (1): _____ Phone: _____ Cell: _____

Emergency Contact (2): _____ Phone: _____ Cell: _____

What is your primary disaster plan?

- ___ 1. Stay with family or others. Provide Name/ Address/ Phone:
- ___ 2. Stay at home. Do you have a generator? Yes No
- ___ 3. Evacuate to a shelter. (A caregiver must accompany you to the shelter and stay with you.)
- ___ 4. Other (Please Explain)

Do you have transportation to a shelter or the place you will be staying? Yes No

Can you sit up and ride in a car or van? Yes No Do you need a wheelchair lift? Yes No

Do you require an ambulance for transportation? Yes No Primary Reason:

By signing this form, I give my authorization for medical information contained herein to be released to Albemarle Regional Health Services/ Albemarle Home Care, Perquimans County Department of Social Services, The Albemarle Commission, and Perquimans County Emergency Management. This information contained here will be kept confidential. GS # 45 C.F.R. 164.510 (b)(4)

Signature: _____ Date: _____

Please return completed form to: Perquimans County Emergency Management
PO Box 45
Hertford, NC 27944