Project Goals

- *Identify population that need special care in the event of an emergency*
- *Ensure applicants are contacted during emergency situations*
- *Maintain accurate and update database*

Emergency Management Mission

Preparedness

Response

Recovery

Mitigation

Place Stamp Here

Hertford County Emergency Management
P.O. Box 566
Winton, NC 27986

Hertford County Voluntary Special Needs Registry

In Partnership with:

Hertford County Department of Social Services

Hertford County Office of Aging

Hertford County Public Health
Prevent. Promote. Protect.

University Health Systems
Roanoke-Chowan Hospital

EM
HERTFORD COUNTY

Hertford County Emergency Management

Voluntary Special Needs Registration Form

The Hertford County Voluntary Special Needs Program is designed for those who have special physical or medical needs and who may require evacuation or shelter assistance in the event of an emergency. **Fill out the form completely** and mail it to the return address listed on the back. Registration data is maintained by the Office of Emergency Management and a copy will be reviewed by the Hertford County Health Department.

Personal Data

Print Clearly

Today's Date: _____ Age: _____ Birth Date: _____ Sex: M ☐ F ☐

Last Name: _____ First Name: _____

Physical Address: _____

City: _____ Zip Code: _____ Height: _____ Weight: _____

Mailing Address (if Different): _____

Primary Telephone: _____ Primary Language: English ☐ Spanish ☐

Emergency Contact Name: _____ Other ☐ (list) _____

Relationship: _____ Phone _____

Housing Data

Residence Type: House/Duplex ☐ Apartment/Complex ☐ Mobile/Manufactured ☐

Name of Residential Development/Complex: _____

Habitation: Live Alone ☐ Live with another or with others ☐ How many? _____

Transportation Data

In Case of Emergency- Will You…?

Stay at Home ☐

Evacuate to Shelter ☐

Stay with Family ☐

Evacuate Out of Area ☐

Do you need Emergency Transportation to a shelter?

No, I will transport myself ☐

Yes ☐ Bus ☐

Wheelchair Bus ☐

Ambulance ☐

Companion or Caregiver Who Will Accompany You (only one):

Name: _____ Relationship: _____ Phone: _____

Name: _____ DOB: _____

Medical Data

Health and Medical Contacts:

Primary Physician: _____ Phone: _____

Home Health Agency: _____ Phone: _____

Medical Conditions/Needs - Please review carefully and check all those that apply:

☐ Require Electricity (explain below)
☐ Oxygen Dependent
☐ Respirator Dependent
☐ Dialysis Dependent
☐ Diabetes
☐ Heart Condition (explain below)
☐ Acute Memory Loss (required caregiver)
☐ Arthritis
☐ High Blood Pressure
☐ Partial Paralysis (explain below)
☐ Hearing Impaired
☐ Slight Impaired
☐ Mobility Impaired
☐ Use walker, cane, or wheelchair
☐ Bedridden (explain below)
☐ Open Wounds, Sores (explain below)
☐ Service Animal (explain below)
☐ Require Special Diet (explain below)
☐ Contagious Condition (explain below)
☐ Amputee (explain below)
☐ Deaf
☐ Blind

Please explain: _____

Allergies: _____

Critical medications: _____

Other issues: _____

In an Emergency I, _____ authorize rescuers to enter my home.

(Print Name)

I certify that this information contained herein is true and correct. I understand that shelter will only be provided for the duration of the emergency and that alternative arrangements should be made in advance if I cannot return to my home. Should I require hospital or assisted living care, I understand I must make arrangements for myself. I understand pursuant to Federal Public Law 104-191, Health Insurance Portability and Accountability Act (HIPAA) of 1996, you have a right to privacy regarding disclosure of confidential health care information, and all information you provide herein shall be kept confidential.

Signature: _____ Date: _____

Representative Signature: _____ Date: _____

Return: Fold sheet, tape close where return address is showing, place stamp on and mail. Registration must be done annually and forms are available online at http://www.hertfordcountync.gov/county-departments/EM/EM/snregform.pdf