POLK COUNTY ACCESS &

FUNCTIONAL NEEDS **REGISTRY**

This program is designed for those who have special physical and/or medical needs and may require evacuation and/or shelter assistance in the event of an emergency.

This information is requested pursuant to North Carolina General Statute 166A, which mandates that all information contained within is confidential and exempt from disclosure and can only be made available to emergency response agencies in the event of an emergency.

PERSONAL ENROLLMENT

Name: _____
Last First Middle

Address: _____
Street *(Physical Address)* City Zip Code

Date of Birth: _____/____/_____ Telephone Number: _____
(Required)

Residence: ☐ House/Duplex ☐ Mobile Home ☐ Apartment/Condo

Living Situation: ☐ Living Alone ☐ With Spouse ☐ With Spouse & Children ☐ With Children
☐ With Parent(s) ☐ With other Relatives ☐ With Non-Relatives

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Person Completing Form:_____ Relationship:_____ Phone:_____

Address:_____

Home Health or Assisting Agency: _____ Phone:_____

SPECIAL MEDICAL NEEDS (Check those that apply)

- ☐ Medical Dependent on Electricity
- ☐ Mental Health Challenged
- ☐ Hearing Challenged
- ☐ Memory Challenged
- ☐ Speech Challenged
- ☐ Sight Challenged
- ☐ Mobility Challenged
- ☐ Insulin Dependent
- ☐ Respiratory Dependent
- ☐ Walker / Cane
- ☐ Bedridden
- ☐ Incontinence
- ☐ Wheel Chair Bound
- ☐ Oxygen Dependent
- ☐ Anxiety/Depression
- ☐ Dialysis Dependent
- ☐ Emergency Alert Monitor
- ☐ Special Dietary Needs
- ☐ Other: _____

_____

_____

Medical Problems (Please be specific)

_____
_____
_____
_____
_____

List all medical equipment that would be needed in a shelter during an emergency situation:

_____
_____
_____
_____

Medications:

Name of Medication	*Dosage*	*Name of Medication*	*Dosage*

Allergies:_____
_____
_____
_____

Primary Care Physician: _____ Phone: _____

Do you have a "Do Not Resuscitate Order" in place? Yes _____ No _____ *If yes, please attach a copy*

ASSISTANCE REQUIRED

Transportation to a shelter needed: YES____ NO____ Assistance in a Shelter: YES____ NO____

Check Needs:
- ☐ Bus
- ☐ Car
- ☐ Wheel Chair Van

Check Needs:
- ☐ Personal Care
- ☐ Feeding
- ☐ Taking Medicine
- ☐ Other (Specify) _____

_____

Notes: In the event of an actual emergency, remember that the emergency responders are limited and it may take some time to get to your location due to different factors such as weather and trees down blocking the roadway. Make sure you have an emergency kit ready in case emergency responders are delayed.

Special Needs individuals going to a shelter must be accompanied by their personal care giver.

The information contained herein is true and correct to the best of my knowledge. I have read the information sheet attached and I understand the limitation on the services and level of care available. I understand that assistance will be provided only for the duration of the emergency and that alternative arrangements should be made in advance in the event I am not able to return to my home. I also understand that I will be responsible for any charges and costs associated with hospital or other medical facility care or medical transportation.

Name of person filling out form: _____
Print Name Signature

Signature of Special Needs Recipient: _____

Date: _____

Please mail completed form to:
Polk County Emergency Management
Attn: Special Needs
PO Box 308
Columbus, NC 28722