ROBESON COUNTY
SPECIAL NEEDS REGISTRY

Last Name ____________ First Name ____________ MI ______ Date of Birth MM/DD/YYYY ______ ☐ Male ☐ Female

Street Address ____________ City ____________ State ______ zip ______ Primary Phone ____________

First District ____________ Language ____________ Alternate Phone ____________

Living Situation (Check One) ☐ Live Alone ☐ With Spouse/Significant Other ☐ With Children ☐ With Parents

☐ Other (Explain) ____________

Medical History (Check and complete all that apply to the registrant's condition). ☐ Allergies ☐ Asthma/Emphysema/COPD ☐ Bedridden

☐ Developmentally Disabled ☐ G-tube Feeders ☐ Hearing Impaired ☐ Insulin Dependent ☐ IV Medication ☐ Medications (Explain Below)

☐ Memory Impaired (Explain Below) ☐ Mental Health Condition ☐ Ostomy Care ☐ Oxygen Concentrator or Ventilator ☐ Continuous ☐ Intermittent

☐ Physically Disabled ☐ Portable Oxygen Machine ☐ Refrigeration for Medication ☐ Required or life-Sustaining Equipment ☐ Seizures

☐ Special Dietary Needs ☐ Speech Impaired ☐ Suction Machine ☐ Vision Impaired ☐ Walker ☐ Wheelchair bound

☐ Other (Explain) ____________

Explain any that have been checked above. List all known diagnoses, medications, etc.

____

____

Disaster Plan ☐ Stay with family or others ☐ Stay at home ☐ Evacuate to a shelter Type Needed ____________

☐ Will bring a service animal or pet to the shelter ☐ Other (Explain) ____________

Emergency Contact information and Medical Provider Information (Fill in all that apply)

Emergency Contact ____________ Work Phone ______ Home Phone ______ Cell Phone ______

Physician Name ____________ Phone ______

Pharmacy Name ____________ Phone ______

Home Health Care Agency (or personal caregiver) ____________ Phone ______

Respiratory Equipment Provider (if applicable) ____________ Phone ______

Registrant Signature: ____________ Date: ______

The information contained here is true and correct to the best of my knowledge. I understand that assistance will be provided only for the duration of the emergency, and that alternative arrangements should be made in advance in case I am not able to return to my home. __________ (Initial)

I understand, based on the information I have provided, that I may or may not be assigned to a special needs shelter based on the criteria stated in the information provided. __________ (Initial)

I understand that I am responsible for assisting in the provision of any prescription medications, oxygen supplies, medical equipment, and special dietary items that I may require during an emergency. ____________ (Initial)

I also understand that I will be responsible for any charges and costs associated with hospital and other medical facility care or medical transportation. __________ (Initial)

I grant permission to medical providers and transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs. __________ (Initial)

I hereby grant permission for the release of this information to emergency response agencies and pre-authorize these agencies to enter my residence for the purpose of emergency search and rescue. __________ (Initial)

I understand my participation in this registry is voluntary and all information maintained will be strictly confidential, used only for emergency purpose and hereby request registration in the Robeson County Special Needs Registry Program. __________ (Initial)

Registrant Signature: ____ Date: ____________________

Caregiver: ____ Date: ____________________
(If Registrant is unable to sign)
Relationship to Registrant (if any): __________________________________

Please mail the completed form to:

Robeson County Department of Social Services
Service Program Administrator
Attn: Special Needs Registry
120 Glen Cowan Road
Lumberton, NC 28360