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: _____
(MM/DD/YYYY)

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: _____
(MM/DD/YYYY)

Caregiver: _____ Date: _____
(If Registrant is unable to sign) **(MM/DD/YYYY)**

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

Email to: Connie Oxendine - connie.oxendine@dss.co.robeson.nc.us

or Fax to: 910-737-5058