Onslow County Special Needs Citizens Information Form

Purpose: This form is designed to help the County assist the citizens during a time of emergency and those that may need assistance in evacuation and/or sheltering needs. All information is confidential.

Directions: Patient information needs to be updated as changes occur (medications, plans, conditions, etc…).

DATE COMPLETED _____

LAST NAME _____ FIRST NAME _____ MIDDLE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PRIMARY PHONE _____ TTY/VIDEO PHONE_____ EMAIL _____

GENDER: **M** **F** DATE OF BIRTH _____ AGE _____ LANGUAGE_____

PATIENT PHYSICIAN _____ PHONE _____

EMERGENCY CONTACT #1 _____ RELATIONSHIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMERGENCY CONTACT #2 _____ RELATIONSHIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

PERSON COMPLETING FORM _____ (will you be the primary contact for updating the form?)

PRIMARY MEDICAL HISTORY (check all that apply):

- ☐ ALZHEIMER'S
- ☐ ANGINA
- ☐ ASTHMA
  - ☐ INHALER
  - ☐ CPAP
- ☐ BRONCHITIS
- ☐ CHRONIC ILLNESS
- ☐ DIABETES
  - ☐ INSULIN DEPENDENT
- ☐ DIALYSIS
- ☐ EMPHYSEMA
- ☐ HEART ATTACK
- ☐ HEART FAILURE (CHF)
- ☐ HIGH BLOOD PRESSURE
- ☐ INTERNAL DEFIBRILLATOR
- ☐ PACEMAKER
- ☐ PNEUMONIA
- ☐ RAPID HEART RATE
- ☐ SEIZURES
- ☐ STROKE
- ☐ OTHER: _____

SECONDARY MEDICAL HISTORY (check all that apply):

- ☐ LIVES ALONE
- ☐ LIVES IN MOBILE HOME
- ☐ SERVICE ANIMAL
- ☐ SIGHT IMPAIRED
  - ☐ BLIND
  - ☐ OTHER_____
- ☐ COMMUNICATION IMPAIRMENT
  - ☐ SPEECH IMPAIRED
  - ☐ HARD OF HEARING
  - ☐ DEAF
  - ☐ NON-ENGLISH SPEAKING
  - ☐ REQUIRES 24 HOUR CARE
- ☐ MEDICAL ELECTRICITY REQUIRED
  - ☐ OXYGEN
  - ☐ VENTILATOR
  - ☐ FEEDING PUMP
  - ☐ DIALYSIS
  - ☐ OTHER_____
- ☐ MOBILITY IMPAIRED
  - ☐ BEDRIDDEN
  - ☐ WHEELCHAIR
  - ☐ WALKER
  - ☐ CANE

ALLERGIES _____

MEDICATIONS _____

_____

_____

OXYGEN PROVIDER _____ PHONE (_____)_____-_____

PHARMACY _____ PHONE (_____)_____-_____

HOME HEALTH PROVIDER _____ PHONE (_____)_____-_____

OTHER INFO _____

For Office Use Only
REV: 10/2016

WebEOC File # _____
Date of Entry _____

Onslow County Special Needs Citizens Information Form

My Personal Disaster Plans

1. Plan for Sheltering at Home
   - ☐ I will have all necessary medications and equipment.
   - ☐ I will have a list of current medication from my pharmacist.
   - ☐ I will have a disaster supplies kit.
2. Plan for Evacuation
   - ☐ Go to a shelter:
     Caregiver Name _____ Phone Number _____
   - ☐ Stay with family/friend:
     Address_____ Phone Number _____
3. Transportation
   - ☐ I have transportation: Provided by _____
   - ☐ I will need assistance with transportation
4. Medical Records
   ☐Will be in my caregivers possession ☐Will be in my sole possession
5. Do you have a service animal? ☐ Yes ☐ No
   (When bringing a service animal to a shelter, please have identification indicating your need for the animal.)
6. Do you have a pet? ☐ Yes ☐ No
   If yes, list Type and Size/Weight _____
   My Pet's Disaster Plan _____
   _____

Information Release
I certify that the above information is correct. I hereby grant permission to Onslow County Department of Emergency Services and Emergency Operations Center workers to use this information for the following purposes ONLY: (1) to include my name/information in the County Special Needs Registry; and (2) to give to emergency response agencies for assistance with evacuation or aid in the event of a disaster or emergency. **All information is confidential.**

SIGNATURE: _____ DATE: _____

GUARDIAN / CARETAKER: _____

Report prepared by:

AGENCY/ORGANIZATION: _____ PHONE _____

MAIL, EMAIL or FAX form to:

Special Needs Registry
c/o Onslow County Emergency Services
1180 Commons Dr. N
Jacksonville, NC 28546
emergencyservices@onslowcountync.gov

FAX: 910-455-6767

Questions/Comments: (910) 347- 4270

****It is your responsibility to verify your contact information with Onslow County Emergency Services at least annually. If we are unable to reach you, you will be removed from the Special Needs Registry. ****