BOONE COUNTY EMERGENCY MANAGEMENT
SPECIAL NEEDS REGISTRY

This program is designed for those who have special physical or medical needs that may require special assistance in the event of a major emergency or disaster. In the event of an actual emergency, response agencies will attempt to provide the necessary assistance but because of significantly increased demands on government resources this cannot always be assured. To best guarantee personal safety, individuals should take the necessary advanced precautions and follow planning guidance issued by governmental agencies.

PERSONAL INFORMATION		**New Application:** □ **Update of Previous Application:** □	
Last Name:	First Name:	Date of Birth:	Sex: □ M □ F
Street Address:	City:	Zip:	Phone:
Mailing Address *(If different)*:	City:	Zip:	Primary Language:
Name of Subdivision, MH Park, Apt. Bldg., etc.	Residence Type: □ Apartment □ House □ Moble Home Living Situation: □ Lives Alone □ With Spouse □ With Children □ With Parents □ Other		

MEDICAL INFORMATION: (Check and complete those that apply to your condition.)

□ Bedridden	□ Hearing Impaired	□ Anxiety/Depression
□ Walker	□ Memory Impaired	□ Colostomy or Ileostomy
□ Wheelchair Bound	□ Mental Health Impaired	□ G-Tube Feeder
	□ Sight Impaired	□ Stroke
□ Cardiac History	□ Speech Impaired	□ Seizures
□ Dialysis		□ Electricity Dependent
□ Incontinent	□ Emergency Alert Equipment	□ Insulin Dependent
□ Life Sustaining Medications		□ Oxygen Dependent

Allergies (List):	**Pet Information:**	
	□ Cat	#
	□ Dog	#
Special Dietary Needs (Explain):	□ Service Dog	#
	□ Other	#

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REQUIRED ASSISTANCE:		
Transportation: □ Automobile □ Van with Wheel Chair Lift □ Stretcher □ Ambulance		Personal Assistance: □ Personal Care □ Feeding □ Taking Medications □ Other

EMERGENCY CONTACT INFORMATION:		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Physician:	Clinic:	Phone:
Pharmacy:		Phone:
Home Health Care Agency:		Phone:

AUTHORIZATION:

I agree that my information be added to the Special Needs Registry. I give Boone County Emergency Management authorization to share this information with other local support agencies in the event of a disaster or emergency. I also grant emergency response personnel permission to enter my home during search and rescue operations following a disaster or emergency, if necessary, to assure my safety and welfare.

Signature: _____ Date: _____

Legal Guardian (If Applicable): _____ Date: _____

EMERGENCY MANAGEMENT USE ONLY
□ Approved □ Denied Reason:
□ Public Shelter-Needs can be met in non-medical facility
□ Hospital-Requires acute medical care
Quadrant: □ NW □ SW □ NE □ SE
Letter Sent: Initials:

Return Form to: **Boone County Emergency Management**
400 East Prospect
Harrison, AR 72601
Ph: 870-741-2950 **Fx: 870-741-6949**