Stonington Special Needs Emergency Registry

General Information

Resident in Need of Assistance

Name (Required): _____

Date of Birth (Required): _____

Preferred Language (Required): _____

Address (Required):

Street: _____

Address Line 2: _____

City, State, Zip: _____

Phone Number (Required): _____

Email: _____

Emergency Contact

Name (Required): _____

Relationship (Required): _____

Address (Required):

Street: _____

Address Line 2: _____

City, State, Zip: _____

Phone Number (Required): _____

Primary Contact #

Email: _____

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Living Situation

Check all that apply to you:

I live in (Required - Select at least one option):

- ☐ Single Family House
- ☐ Mobile Home
- ☐ Condo/Duplex/Townhouse
- ☐ Apartment
- ☐ Other

If Other, please explain:

I live (Required - Select at least one option):

- ☐ Alone
- ☐ With Family/Friends
- ☐ With Caregiver
- ☐ In a Group Home
- ☐ Other

If Other, please explain:

Life Support Systems

Check all that apply to you:

- ☐ NONE
- ☐ Oxygen Tanks
- ☐ Oxygen Concentrator
- ☐ Respirator/Ventilator
- ☐ Tracheostomy
- ☐ IV Line Feeding
- ☐ Urinary Catheter
- ☐ Colostomy/Ileostomy
- ☐ Tube Dialysis
- ☐ Suction
- ☐ Dialysis (Home)
- ☐ (Clinic)
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Other

If Other, please explain:

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Cognitive/Psychiatric/Neurological/Muscular

Check all that apply to you:

- ☐ NONE
- ☐ Seizure Disorder
- ☐ Speech Impaired
- ☐ Non-Verbal
- ☐ Autism Spectrum
- ☐ Cognitive/Developmental Delays
- ☐ Alzheimer's/Dementia
- ☐ Parkinson's
- ☐ Cerebral Palsy
- ☐ Multiple Sclerosis
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ PTSD
- ☐ OCD
- ☐ Other

If Other, please explain:

Sensory

Check all that apply to you:

- ☐ NONE
- ☐ Hard of Hearing
- ☐ Use of Hearing Aid(s)
- ☐ Deaf
- ☐ Use of Cochlear Implant(s)
- ☐ Visually Impaired
- ☐ Legally Blind
- ☐ Other

If Other, please explain:

Mobility

Check all that apply to you:

Checkbox List (Required - Select at least one option):

- ☐ NONE
- ☐ Power-Dependent Wheelchair
- ☐ Wheelchair
- ☐ Walker/Cane
- ☐ Crutches
- ☐ Prosthesis
- ☐ Power Dependent Bed
- ☐ Other

If Other, please explain:

Daily Assistance Requirements

Check all that apply:

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- ☐ NONE
- ☐ Feeding
- ☐ Taking Medication
- ☐ Communicating
- ☐ Transportation
- ☐ Toileting
- ☐ Dressing/Undressing
- ☐ Bathing/Grooming
- ☐ Service Animal
- ☐ At-Home Nurse
- ☐ Other

If Other, please explain:

Other Conditions

Please check all that apply:

- ☐ NONE
- ☐ Diabetes
- ☐ Insulin-Dependent Diabetes
- ☐ Weight between 300-549 lbs
- ☐ Weight between 550-799 lbs
- ☐ Weight greater than 800 lbs
- ☐ Other

If Other, please explain:

Transportation

Check all that apply to you:

When I leave my home, I most frequently use a(n) (Required - Select at least one option):

- ☐ Personal Vehicle
- ☐ Taxi/Car Service
- ☐ Public Bus
- ☐ Dial-A-Ride Med Cab
- ☐ Wheelchair Van/Bus
- ☐ Ambulance
- ☐ Other

If Other, please explain:

If I needed to evacuate, I would be accompanied by (Required - Select at least one option):

- ☐ No One
- ☐ Caregiver
- ☐ Family/Friend
- ☐ Other

If Other, please explain:_____

☐ By signing this form, I agree to permit my information to be shared with the Town of Stonington's Human Services Department, as well as local emergency first responders. I understand that this is a voluntary program and while the Town of Stonington will share this information in order to better assist me during an emergency, they cannot guarantee assistance in all cases.

Signature (Required): _____

If completing online, your typed name acts as your signature.

Printed/Typed Name: _____

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Date: _____

If you are completing this form on someone's behalf, please indicate your name and relationship to that individual: