

Plainsboro Twp. Office of Emergency Management Special Needs Registry

Personal/Residency Information

- First Name: _____ Middle Initial: _____
Last Name: _____
- Sex Male Female
- DOB _____ Date Form Completed: _____
- Type of Residence: Private Special Needs Public Housing
- Facility/Residence/Community Name: _____
- Street Address: _____ ***Not a PO Box**
Address Line 2: _____
Apartment Building Name and Number: _____
Floor Level: _____
- Municipality/City: _____
- Phone Number: _____
- Cell Phone: _____
- E-mail Address: _____
- How well do you understand the English language?
 Well Not well Not well at all
- Primary language spoken: _____
- If Special Needs, Special Needs Residence Type:
 Assisted Living Retirement Community Senior Housing
 Group Home Residential Health Care Facility Other
- How many people including yourself are in your household?
 Live alone 1 other person 2 other persons 3 other persons
 more than 3 people
- Are you responsible for minor children living with you? Yes No
If yes, how many? _____

Emergency Contact Information

- First Name: _____ Middle Initial: _____
Last Name: _____
- Street Address: _____ ***Not a PO Box**
Address Line 2: _____
City: _____ State: _____ Zip Code: _____
- Phone Number: _____ Cell Phone : _____
- Fax Number: _____
- E-mail Address : _____

The following information will further help us prepare for your evacuation

- Do you have pets living with you? Yes No
- Do you have a service animal? Yes No

- Weight Range Less than 300 lbs. 300 lbs. or over
- Are you bed bound? Yes No
- You walk with the assistance of :
 - No assistance Another person Cane Crutches Walker
 - Service Animal Other
- Do you use a Wheelchair or scooter? Yes No
 Type: Manual wheelchair Motorized wheelchair Scooter
- Sight Impaired? No impairment Need glasses Blind
- Hearing Impaired? No impairment Hearing aid Deaf
- Check all items that apply :
 - Use Oxygen
 - Use respirator
 - Cognitive Impairment
 - Alzheimer/ dementia
 - Developmental disability
 - Mental Health condition

Evacuation Transportation Requirement

- Do you require transportation? Yes No
 If yes:
 - Standard transportation Yes No
 - Can you slide transfer? Yes No
 - Do you need vehicle with a lift? Yes No
 - Must be transported by Ambulance? Yes No

The following information will be helpful for your possible stay at an Emergency Shelter

- Do you have :
 - Personal Emergency Kit? Yes No
 - Medication list? Yes No
 - File/Vial of Life? Yes No
 - Food Allergies? Yes No
 If yes, specify _____
 - Other Allergies? Yes No
 If yes, specify _____
 - Dialysis required? Yes No
 If yes, specify how often _____

This form was filled out by Self Family Member Other (name) _____

I am submitting this form voluntarily, for the use by emergency personnel, in the event that I should require assistance during an emergency.

Signature

Date