

Emergency Planning & Evacuation Registry Form for Citizens with Special Needs

The Essex Health Department and Emergency Management Director maintain a database of seniors and people with special needs who may require evacuation and shelter assistance during a natural or man-made disaster.

People with medical disabilities or transportation needs are encouraged to pre-register with the Essex Health Department for these services.

People who register will be asked to keep their information current and to update it annually. Personal information will be kept confidential in accordance with state and federal law, and will be maintained by the Essex Health Department. Data will only be used by emergency personnel during preparedness planning and evacuations.

The registration form is attached. It is also available in the Essex Town Hall, on the Essex Health Department website at www.essexct.gov, and from various resources such as Meals-on-Wheels, FISH (Friends in Service Here), Visiting Nurses of the Lower Valley, local libraries and the Essex Ambulance Association.

Completed forms should be mailed to:
Essex Health Department, 29 West Avenue, Essex, CT 06426.

Registration Instructions:

A separate form is required for each individual requesting evacuation registration. Please retain a copy for your records.

Please Answer ALL questions.

If your form is missing information (such as correct phone number, address, etc.) we may not be able to contact you. We cannot determine your needs unless you answer ALL questions regarding any medical and transportation requirements. Upon receipt of your completed form, your information will be entered into our restricted database.

Keep your registration information current.

You are responsible for informing the Health Department of any changes. If you move, change your phone number, or no longer need to be registered, let us know immediately so your file can be updated. If we cannot contact you during an emergency evacuation, we cannot assist you.

- This registry will be updated annually.
- New forms will be mailed to registrants to update information and verify eligibility.
- Registrants who **DO NOT** reply or cannot be reached will be removed from our registry.
- Registration is **FREE** and **VOLUNTARY**. Your information is used solely by those public health and safety agencies who will assist you during an emergency. It does not imply or guarantee any other service.

Questions or concerns may be directed to the Health Department at 860-767-4340 x 118.

PLEASE PRINT OR TYPE

WHO YOU ARE:

Full Name: _____

Gender: Male Female

English Spoken? Yes No

Date of Birth: _____

If "no," what is your primary language? _____

RESIDENCE INFORMATION:

Street Address: _____

- Essex
- Centerbrook
- Ivoryton

Phone #: _____ Alternate#: _____ TDD/TT: _____

Do you live in a: Single Family House Rest Home/Assisted Living Facility
 Apartment Condominium

If electricity goes out, do you have an alternate heat source? Yes No

If yes, what type of alternate heat source will you use to heat your residence?

- Wood/Pellet stove Electrical Generator to power the furnace
- Wood Burning Fireplace Other: _____

Do you live by yourself? Yes No

If no, who lives with you? Spouse Family Member Caregiver Companion

Their Name(s) _____

Would this individual be capable of assisting you during an emergency? Yes No

If you are a part-time resident (i.e. summer only), please list the months you reside at this location.

Do you have a primary care giver in the area? Yes No

Name: _____ Phone No. _____

Relationship to you: _____ Does a caregiver live with you? Yes No

Are you seen by a health aide or a visiting nurse? Yes No

If yes, number of visits per week: _____ Anyone else? _____

Do you have any pets? Yes No

If yes, please give the name, type and weight of the pets: _____

EVACUATION PLANNING

If ordered to evacuate, do you have an evacuation plan? Yes No

Do you have a car? Yes No

Do you drive? Yes No

Do you have someone to drive you? Yes No

If no, will you go by: wheel-chair van, ambulance other? _____

Name of the transport company: _____ Phone No: _____

Will your companion/spouse/caregiver go with you? Yes No

Name: _____ Relationship: _____

Will you need assistance to evacuate to a shelter? Yes No

SHELTER PLANNING

What is your plan for shelter if evacuation is necessary? _____

If you have no plan, would you like Office of Emergency Management to contact you? Yes No

SPECIAL CONDITIONS

Elderly/frail: Yes No

Respiratory problems: Yes No

Difficulty walking: Yes No

Cardiac problems: Yes No

Blind or sight impaired: Yes No

Paralysis: Yes No

Deaf or hearing impaired: Yes No

Memory impaired: Yes No

Diabetic: Yes No

Mental disability: Yes No

Insulin Dependent Yes No

Pills Yes No

No Treatment Yes No

Allergies: Yes No Describe Allergies: _____

Other Conditions: _____

TREATMENT / EQUIPMENT

Do you take prescription medications: Yes No

Do you have a current list of medications? Yes No

Respirator: Yes No

Foley Catheter: Yes No

Tracheotomy: Yes No

Feeding Tube: Yes No

Dialysis: Yes No

Home Dialysis: Yes No

Intravenous Line: Yes No

PICC line/Hickman Catheter: Yes No

Oxygen: Yes No

Oxygen Usage: Continuous Part-time Oxygen _____liter flow

Oxygen supplier's name/type of equipment: _____

Other emergency equipment: _____

AMBULATION CAPACITY

Are you confined to a: Bed Wheel Chair Power Wheel Chair

Do you use a: Walker Wheel Chair Cane Service Animal

Other assistance needs: _____

IMPORTANT NAMES AND PHONE NUMBERS:

Physician Name: _____ Phone _____

Hospital Preference: _____

Home Health/Hospice Name: _____ Phone _____

Pharmacy Name: _____ Phone _____

Care Giver/Visiting Nurse Assoc. Name: _____ Phone _____

Comments/Notes: _____

PERSON / RELATIVE CONTACTS:

Can we release your evacuation status to anyone? Yes No If yes, list person(s) below:

Name: _____ Phone: _____

Relationship: _____