**Cranbury Township Special Needs Registry**

The following information is strictly for identification purposes, with minimum data requested from individuals with disabilities, or frail and elderly participants who volunteer to register.

**Personal/Residency Information**

1. First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Sex □ Male □ Female
2. Age \_\_\_\_\_\_\_\_\_\_\_\_ Date Form Completed: \_\_\_\_\_\_\_\_\_\_
3. Type of Residence: □ Private □ Special Needs □ Public Housing
4. Facility/Residence/Community Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\*Not a PO Box**

Address Line 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Floor level \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cranbury, NJ

1. Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. How well do you understand the English language?

□Well □Not well □ Not at all

1. Primary language spoken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. If Special Needs, Special Needs Residence Type:

□Assisted Living □Retirement Community □ Senior Housing

□ Residential Health Care Facility □ Other

1. How many people including yourself are in your household?

□ Live alone □ 1 other person □ 2 other persons □ 3 other persons

□more than 3 people

1. Are you responsible for minor children living with you? □ Yes □ No

If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Information**

1. First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\*Not a PO Box**

Address Line 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_

1. Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. E-mail Address : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The following information will further help us prepare for your evacuation**

1. Do you have pets living with you? □ Yes □ No
2. Do you have a service animal? □ Yes □ No
3. Weight Range □ Less than 300 lbs. □ 300 lbs. or over
4. Are you bed bound? □ Yes □ No
5. You walk with the assistance of :

□ No assistance □ Another person □ Cane □ Crutches □ Walker

□ Service Animal □ Other

1. Do you use a Wheelchair or scooter? □ Yes □ No

Type: □ Manual wheelchair □ Motorized wheelchair □ Scooter

1. Sight Impaired? □ No impairment □ Need glasses □ Blind
2. Hearing Impaired? □ No impairment □ Hearing aid □ Deaf
3. Check all items that apply :

□ Use Oxygen

□ Use respirator

□ Cognitive Impairment

□ Alzheimer/ dementia

□ Developmental disability

□ Mental Health condition

**Evacuation Transportation Requirement**

1. Do you require transportation? □ Yes □ No

If yes:

Standard transportation □ Yes □ No

Can you slide transfer? □ Yes □ No

Do you need a 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**

1. 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

***Kindly mail the completed form to Chief Michael J. Owens, Cranbury Township Police Department, 1 Logan Drive, Cranbury, NJ 08512 or email to the Chief’s Administrative Assistant at lgrogan@cranbury-nj.com***