

SPECIAL NEEDS CATEGORY: _____

CONTROL/CASE #: _____

SPECIAL NEEDS / REGISTRATION FORM

HAMPTON JAMES CITY COUNTY NEWPORT NEWS POQUOSON WILLIAMSBURG YORK COUNTY HEAD?S UP PROGRAM

Purpose: To provide information to public safety agencies related to an individuals disability, medical, mobility or other problem, that emergency responders should be aware of during an emergency. This does not take the place of an individuals responsibility to plan and prepare for transportation and / or sheltering in the event of an emergency. Complete all parts of this form. A separate form must be prepared for each special needs individual residing at the same location. **Please PRINT all information.** When completed, return it to the appropriate locality at the address listed on the reverse of this form.

PERSONAL INFORMATION - PLEASE PRINT

Last Name:	First Name:	M.I.	Wt:	Age:	Birth Date (mm dd yr): / /
Street Address:			City:		ZipCode:
Complex Name:		Apt #	Bldg. #	Floor #	Elevator? Y/N Ramp? Y/N
Mobile Home: Y/N		Number of other occupants at this address:			
Phone #:	TDD #:	Other contact number:			

EMERGENCY CONTACT INFORMATION (Contacts must have a phone number)

Name	Mailing Address (if not in local area)	Home Phone	Work Phone
1.		() --	() --
2.		() --	() --

DISABILITY/MEDICAL INFORMATION

<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Visually Impaired	<input type="checkbox"/> Sight/Other Assistance Animal	<input type="checkbox"/> Electrically Dependent
<input type="checkbox"/> Mentally Impaired	<input type="checkbox"/> Ventilator Dependent	<input type="checkbox"/> IV Therapy	<input type="checkbox"/> Indwelling Catheters or Drains
<input type="checkbox"/> Oxygen required at _____ lpm		<input type="checkbox"/> Communications Difficulty <input type="checkbox"/> Needs TDD <input type="checkbox"/> Needs Signer <input type="checkbox"/> Does Not Speak English Language Spoken:	

Specific Medical Problem(s) or Disability(ies):

Allergies:

Other Life Support Requirements:

Special Medic Alert / Life Call Device Type: _____ Alarm Company: _____ Phone #: () --

Mobility: Walks by Self Walks with Assistance Wheelchair Bedridden - May individual be moved by wheelchair? Yes No

Home Health Care Agency:	Agency Point of Contact:	Agency Phone #
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I understand that it is my responsibility to keep this information provided current, and that I am aware of my responsibility for all expenses incurred in association with medical evaluation and special sheltering in a hospital or nursing facility. I accept the conditions as specified and grant permission to the above indicated jurisdiction to release this information to emergency response agencies. The information may be entered into an existing Computer Aided Dispatch System (CADS) to be transmitted via two-way radio to emergency responders in the event of an emergency.

Date: _____ Signature: _____ Individual Guardian

It is important to contact the emergency management agency listed below whenever the information on this form changes.

MAIL THIS COMPLETED FORM TO THE APPROPRIATE ADDRESS BELOW

City of Hampton Office of Emergency Management 40 Lincoln Street Hampton, Virginia 23669 757-727-6414 757-727-6774 (fax)	City of Newport News Office of Emergency Management 513 Oyster Point Road Newport News, Virginia 23602 757-269-2900 757-269-2905 (fax)	City of Williamsburg Office of Emergency Management 412 North Boundary Street Williamsburg, Virginia 23185 757-220-6220 757-220-6229 (fax)
James City County Office of Emergency Management 3127 Forge Road Toano, Virginia 23168 757-566-4315 757-566-0842 (fax)	City of Poquoson Office of Emergency Management 830 Poquoson Avenue Poquoson, Virginia 23662 757-868-3501 757-868-8477 (fax)	York County Fire and Life Safety Emergency Communications Division PO Box 532 Yorktown, Virginia 23690 757-890-3600 757-890-3609 (fax) 8:15 AM - 5:00 PM M-F except holidays.

Additional Information:
Special Directions to Residence:

FOR OFFICIAL USE ONLY

Date Received:	Date Entered:	Fire District:	Law Enforcement District:
Date Letter Sent:	Date PSC Notified:	Update ? Y N	Purge Date:
Enter by Authority / Agency:			Phone #:
Mailing Address:			
Comments:			