Village of South Barrington
30 South Barrington Road
South Barrington, IL 60010
Ph 847-381-7510 / Fx 847-381-0024

CONFIDENTIAL

SPECIAL NEEDS REGISTRY

Your Contact Information:					
Last Name:		First Name:		MI	
_____ Male _____ Female	Do you live alone? _____	Home phone:			
Home Address:		Cell phone:			
		Email 1:			
	South Barrington, IL 60010				
Subdivision:					
Primary Spoken Language:					
Shelter Requirements: (If you must evacuate your residence, where would you go?)					
_____ Shelter _____Stay with Family/Friends					
How would you leave: _____ Transportation available from Family/Friends _____ Need Transportation					
Will you be accompanied to a shelter by a caregiver or family member? _____ Yes _____ No					
If so, how many? _____	Do you have pets? _____ Yes _____ No				
Emergency Contact Information:					
Last Name:		First Name:			
Home phone:		Cell phone:			
		Email 1:			

AUTHORIZATION MUST BE SIGNED:

I certify that the information provided is correct. I understand that I am responsible for all expenses associated with medical evacuation and shelter at a hospital, nursing facility or any specialized equipment needed in a special needs shelter.

I hereby authorize the Village of South Barrington to release this information to other emergency response or human service agencies or officials for the purposes of providing shelter and other required care in the case of a natural disaster or emergency. I give local law enforcement and/or medical personnel permission to enter my home in case of an emergency.

This authorization will expire in two (2) years from the date the authorization is signed. You may revoke this authorization at any time by written notification to the Village of South Barrington, Office of Emergency Management, 30 S. Barrington Rd, South Barrington, IL 60010. Your notice will not apply to information that has been released under this authorization prior to receipt of your revocation of this authorization.

I understand that the Village cannot assure any special assistance during an emergency.

Print name:		Signature:	
		Date:	

Complete front and back of form and return to Village of South Barrington,
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Can you take care of yourself: ____ Yes ____ No	Your Height:		Your Weight:	
Primary Doctor:		Phone:	

Do you receive care through a State agency? _____ Yes _____ No

Name of State Agency:	
State Agency Phone:	

Do you receive Home Care? _____ Yes _____ No

Name of Home Care Agency:	
Home Care Agency Phone:	

Name of Medical Supplier:		Phone:	

Required Medications:

Medication Name:		Dosage:	
Medication Name:		Dosage:	
Medication Name:		Dosage:	
Medication Name:		Dosage:	
Medication Name:		Dosage:	

Mobility:	_____ OK to walk _____ Need assistance _____ Walker, Cane, Crutches
	_____ Wheelchair on occasion _____ Wheelchair bound _____Bedridden

Impairment:	_____ Hearing loss _____ Deaf _____ Vision loss _____ Blind _____ Oxygen dependent	
	Are you Dialysis dependent? _____ Yes _____ No	If yes, how often?

Check what applies:		Colostomy or Ilestomy		G-tube	
Alzheimer's (stage _____)		Contagious Disease _____		High blood pressure	
Ameliorating Lateral Sclerosis ALS		Dementia		Incontinence	
Arthritis (severe)		Diabetes		Mental illness _____	
Back Injury		Emphysema		Multiple Sclerosis	
Cardiac		Epilepsy or Seizures		Osteoporosis (severe)	
Catheter		Fractured bones w/pin care		Parkinson's	
Cerebral Palsy		Full paralysis			
Other:					

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