

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
<input type="checkbox"/> Male <input type="checkbox"/> Female	Do you live alone? <input type="checkbox"/>	Home phone:	
Home Address:		Cell phone:	
	South Barrington, IL 60010	Email 1:	
Subdivision:			
Primary Spoken Language:			
Shelter Requirements: (If you must evacuate your residence, where would you go?)			
<input type="checkbox"/> Shelter <input type="checkbox"/> Stay with Family/Friends			
How would you leave: <input type="checkbox"/> Transportation available from Family/Friends <input type="checkbox"/> Need Transportation			
Will you be accompanied to a shelter by a caregiver or family member? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If so, how many? <input type="checkbox"/>	Do you have pets? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Emergency Contact Information:			
Last Name:		First Name:	
Home phone:		Cell phone:	
		Email 1:	
AUTHORIZATION MUST BE SIGNED:			
<i>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>			
<i>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.</i>			
<i>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>			
<i>I understand that the Village cannot assure any special assistance during an emergency.</i>			
Print name:		Signature:	
		Date:	
Complete front and back of form and return to Village of South Barrington, Office of Emergency Management, 30 S. Barrington Road, South Barrington, IL 60010			

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Can you take care of yourself: <input type="checkbox"/> Yes <input type="checkbox"/> No		Your Height:		Your Weight:	
Primary Doctor:				Phone:	
Do you receive care through a State agency? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Name of State Agency:					
State Agency Phone:					
Do you receive Home Care? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> OK to walk <input type="checkbox"/> Need assistance <input type="checkbox"/> Walker, Cane, Crutches					
<input type="checkbox"/> Wheelchair on occasion <input type="checkbox"/> Wheelchair bound <input type="checkbox"/> Bedridden					
Impairment: <input type="checkbox"/> Hearing loss <input type="checkbox"/> Deaf <input type="checkbox"/> Vision loss <input type="checkbox"/> Blind <input type="checkbox"/> Oxygen dependent					
Are you Dialysis dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, how often?	
Check what applies:					
		Colostomy or Ileostomy		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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