



Specialneeds.pa.org

The Special Needs Registry is designed to help emergency responders plan for and safely evacuate people who may find it difficult to help themselves in the event of a major disaster.

Emergency responders need to know where you are and what assistance you may need to assist in helping to evacuate you quickly and safely.

Complete this form for you or anyone you know who may need assistance in an evacuation. This information is considered CONFIDENTIAL. No information will be intentionally shared with anyone other than the emergency responders.

Mail completed form to: Phoenixville Emergency Management, 140 Church Street, Phoenixville, Pennsylvania 19460

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____ Municipality: _____

Phone: _____ TTY Phone

Secondary Phone: _____ Email: _____

Does Not Have a Phone

Date of Birth: _____ / _____ / _____ Height: _____ Weight: _____
(mm / dd / yyyy) (Feet / Inches) (Pounds)

Personal Information for Emergency Contact:

Please provide the requested information for an individual with whom we can discuss your situation in the event that an emergency necessitates this.

I choose not to provide emergency contact information

FIRST NAME: _____ MI: ___ LAST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

Relationship to Individual: _____ Email: _____

Evacuation Information:

If an emergency requiring evacuation occurred, the individual may have difficulty evacuating because of the following conditions). Check all that apply:

Sight Impaired

Does Not have access to a car

Hearing Impaired

Does Not have a radio

Speech Impaired

Does Not have a television

Physically Impaired

Does Not speak English

Completely Bedridden

Primary Language: _____

Mentally / Memory Impaired

Dementia / Alzheimer's

Has Difficulty Walking & Requires:

Dialysis

Manual Wheelchair

Requires Skilled Nursing

Motorized Wheelchair

Other: _____

Walker / Cane

Attendant to Assist Walking

Requires medical equipment that is not easily transportable:

Oxygen or Concentrator Cylinder

Ventilator

Suction machine

Other Equipment: _____

Duration of Need:

Are ALL of the conditions resulting in the need for evacuation assistance temporary?
(Example: The individual is bedridden due to recent surgery, but is expected to fully recover in a few days or weeks.)

- Yes
- No, the conditions are expected to be permanent

If Yes, Please provide an estimated date when the condition will be resolved

Month: _____ Year: _____

1. Does the person in need have a service animal? (i.e. seeing-eye dog)

- Yes
- No

2. Does the person have pets?

- Yes
- No

3. Does the person in need have medications that must be taken with them if evacuated?

- Yes
- No

4. Does the person in need have a 24 hr. caregiver ?

- Yes
- No

5. Does the person in need require evacuation assistance 24/7 ?

- Yes I need Assistance from ___:___ A.M. / P.M. ___:___ A.M. / P.M.
- No

If there is any information that may be useful for our emergency personnel that cannot be answered in this survey, please list it here: _____
