St. Clair County Persons with a Special Need Registration Form

Office of Emergency Management
200 Grand River Suite 204
Port Huron, MI 48060

Name: | Phone #:

Address:

Mailing Address if different:

Closest Major Intersection

TTD/TTY: | Age | Male ☐ Female ☐

Allergies to medication ☐ No ☐ Yes If yes, please list

Primary Care Physician: | Phone #

Do you have **pets** ☐ Yes ☐ No If yes, how many What kind?

Special Needs

Check all that apply

Physical/Motor	☐ Mild (minimal assistance, cane)	☐ Moderate (Need physical assistance to stand, walker)	☐ Severe (total assistance, bed bound, wheelchair)
Decision Making	☐ Needs Minimal Assistance ☐ Needs Moderate Assistance ☐ Need Total assistance in making decisions I have a guardian ☐		
Hearing	☐ Mild (speak loudly) ☐ Moderate (use hearing aids) ☐ Severe (can not hear)		
Vision	☐ Mild (must have glasses)	☐Moderate	☐ Severe (blind) If checked, do you use a guide dog ☐ Yes ☐ No
Dialysis	☐ Yes ☐ No If yes, How many times per week		
Medications	Do you take medications that would be considered **LIFE SUSTAINING** such as Insulin, Seizure, or Heart medication. ☐ Yes ☐ No Does this medication need to be refrigerated. ☐ Yes ☐ No		
Medications	Do you take medications for a mental illness ☐ Yes ☐ No		

Do you have any breathing problems that require special equipment ☐ Yes ☐ No
If yes please list equipment -

Oxygen Dependent: ☐ Yes ☐No Do you always have a spare available ☐ Yes ☐ No

Do you rely on electricity to operate your oxygen equipment? ☐Yes ☐No:

Who provides your Oxygen:

Do you rely on electricity to operate any other **LIFE SUSTAINING** medical equipment ☐Yes ☐ No If yes, please list the equipment on the top of the reverse side of the form.

Do you have a Home Generator: ☐ Yes ☐ No

Do you currently have an emergency plan in case of a disaster? ☐ Yes ☐No

Do you have emergency food and supplies in case a disaster lasts 72 hours?
☐ Yes ☐ No

Please complete reverse side

Is there any other information needed to assist you in an emergency?	
In the event of an emergency it may be necessary for emergency responders to contact a family member, friend, neighbor or buddy on your behalf. Please list at least two (2) contact person(s) for yourself even if the contact person is out of town.	
Contact #1/ or Guardian if applicable	
Name:	
Address:	
Phone:	
Relationship:	
Contact #2	
Name:	
Address:	
Phone:	
Relationship:	
Contact #3 Out of County	
Name:	
Address:	
Phone:	
Relationship:	
I, ____________________, hereby grant permission to the St. Clair County Office of Emergency Management/Homeland Security to release this information to other emergency response or human services agencies or officials in case of a disaster or evacuation.	
Date:	
Signature:	
Name of person filling out this form, if not the same as above	
Name:	
Address:	
Phone:	
Relationship/Agency:	
Date Signed:	

PLEASE MAIL FORM TO THE ADDRESS ON THE FRONT