Kane County Special Needs Registry

All Information is Confidential

Last Name: _____ **First Name**: _____ **MI**: _____

☐ **Male** ☐ **Female** **Date of Birth**: ____ - ____ - _____

Telephone #: ( ) - _____ **Do you live alone?** ☐ yes ☐ no

Street Address: _____ **Apt #**: _____

City: _____ **Zip**: _____

Home Type: ☐ Mobile / Manufactured ☐ Single Family ☐ APT / Condo ☐ RV

Name of Mobile Home Park: _____

Community or Subdivision Name: _____

Shelter Requirements (If you need to go to a shelter where would you go)

☐ Staying Home ☐ Regular Shelter ☐ Special Needs Shelter ☐ Stay with family/friends

Transportation Requirements

☐ None ☐ To Shelter ☐ To Family/Friends ☐ To Nursing Home ☐ To Hospital

Emergency Contact

Name: _____ **Telephone #**: ( ) - _____

Primary Doctor

Name: _____ **Telephone #**: ( ) - _____

Do you receive care through a State Agency? ☐ yes ☐ no

Agency: _____ **Telephone #**: ( ) - _____

Do you receive care at home ? ☐ yes ☐ no

Agency: _____ **Tx #**: ( ) - _____

Will you be accompanied to a shelter by a caregiver or family member? ☐ yes ☐ no

If yes, How Many? _____

Do you have pets? ☐ yes ☐ no **Can you take care of yourself?** ☐ yes ☐ no

Primary Spoken Language: Arabic Chinese English French German Greek Hebrew
(circle one) Italian Japanese Korean Portuguese Russian Spanish

Your Height: _____ **Your Weight:** _____

Impairment? ☐ Deaf ☐ Hearing ☐ Blind ☐ Visually ☐ Oxygen Dependent

Name of medical supplier: _____

Tx: (___) _____ - _____

Dialysis Dependant: ☐ yes ☐ no **If yes how often?** _____

Required Medications:
Please provide dosage information

Impairment Category B
(circle all that apply)

Alzheimer's Dementia Cardiac Cerebral Palsy
Colostomy Ileostomy Dementia Diabetes
Emphysema G-tube Hearing Incontinence
Catheter Multiple Sclerosis Osteoporosis
Muscular Dystrophy Paralyzed Parkinson's
Stroke Walker/wheelchair/cane/crutches

Impairment Category C
(circle all that apply)

Contagious/Infection Bed bound Cardiac
Full Term Pregnancy Psychosis
Ventilator Dependant Seizures Total Paralysis

Note: When complete please send this form to :

Kane County OEM
719 S. Batavia Ave.
Geneva, IL 60134

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

I hereby grant permission to the Kane County Office of Emergency Management to release this information to other emergency response or human service agencies or officials. I also give local law enforcement and/or medical personnel permission to enter my home in case of an emergency.

_____ _____

Signature **Date**