



**Greene County  
Special Needs Voluntary Registration**

Greene County DSS has incorporated a special needs registry for people with special medical needs who may require special assistance in the event of a disaster, such as a tornado, severe storm, hurricane, or chemical spill. This is a voluntary registration. The information you provide will be confidential in accordance with state law. It will be used by emergency personnel only to assure your safety in the event of a disaster. You may need to be evacuated to safety, or you may need to stay within your home with special assistance. Should you wish to be included in the registry, please complete this form and return it to Greene County DSS. If you have questions regarding this form, please contact **Greene County DSS at 252-747-5932**.

**Assistance dogs are allowed in Special Medical Needs Shelters; however, individuals are responsible for the care of the dog, including bringing food and other essentials. Pets are not allowed in shelters. Please contact Greene County Emergency Management for pet shelter information at 252-747-2544.**

**Individuals who come to a Special Medical Needs Shelter are responsible for bringing a five (5) day supply of medications, medical supplies, and any other items needed to meet their needs.**

**Special Needs Assessment**

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
Physical Street Address: \_\_\_\_\_

Mailing Address (if different than physical address) \_\_\_\_\_

Caregiver: \_\_\_\_\_  
Caregiver Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_  
Emergency Contact Phone: \_\_\_\_\_  
Primary Language: \_\_\_\_\_  
TDD/TTY (for hearing impaired) Yes  No   
Primary Physician: \_\_\_\_\_  
Physician Phone: \_\_\_\_\_  
Home Health Provider: \_\_\_\_\_  
Provider Phone: \_\_\_\_\_  
Pharmacist: \_\_\_\_\_  
Pharmacist Phone: \_\_\_\_\_

**What is your primary disaster plan?**

- \_\_\_\_\_ 1. Stay with family or others: If so, name, address, phone #:  
\_\_\_\_\_  
\_\_\_\_\_ 2. Stay at home. Will you be alone: Yes  No   
Do you have a generator? Yes  No

\_\_\_\_\_ 3. Evacuate to a shelter (if going to a shelter, a caregiver must accompany you to the shelter and stay with you)

**Do you have transportation to a shelter?** Yes  No   
**If No, what are your transportation needs?** Car  Van with lift  Ambulance

**Do you need assistance with walking?** Walks Unassisted  Walks with Assistance  Wheelchair  Bedridden

**Special Needs Include the Following:**

1. Individuals with severe respiratory problems (oxygen or ventilator dependent) that require a power source and/or ambu bag.
2. Individuals dependent on airway suctioning (tracheotomy).
3. Individuals on IV (intravenous) therapy.
4. Individuals requiring tube feeding.
5. Individuals requiring wound care or help with injections on a daily basis.
6. Individuals who are diabetic and require assistance with insulin.
7. Individuals with physical or mental conditions that require daily medical supervision.

**SPECIAL MEDICAL NEEDS: Circle all medical needs that apply to you as defined by the categories listed above.**

1                    2                    3                    4                    5                    6                    7

**Disabilities:** Hearing Impaired  Sight Impaired  Speech Impaired  Contagious Disease  Assistance Dog   
Other: \_\_\_\_\_

**Do you presently live in:** Apartment  House  Mobile Home

**Do you have medical equipment that requires power?** Yes  No

Medical Needs:	Yes		No		Frequency			
	Yes	No	Yes	No				
Life Support			Colostomy (self)		Wound Care			
Feeding Tube			Colostomy (w/assistance)		Dialysis			
Insulin (self)			Illeostomy (self)		IV Fluids			
Insulin (w/assistance)			Illeostomy (w/assistance)		Suction Unit			
Ventilator			Portable Oxygen Tank					<b>Hours Per Day</b>
24 hour caregiver			Concentrator (for oxygen)		Oxygen			

**If you receive oxygen, who is your oxygen provider:** \_\_\_\_\_

**Do you have supplies or equipment that you cannot transport?**  Yes  No If yes, please list: \_\_\_\_\_

**I certify that the above information is correct. I understand I am responsible for all expenses associated with medical evacuation and shelter at a hospital. I hereby authorize Greene County Social Services to release, use or disclose this information to other emergency response or human services agencies or officials. I also give law enforcement permission to enter my home in case of an emergency.**

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**Registry forms can be obtained at any of the following agencies:**

Greene County Emergency Services  
201 Martin L. King Jr. Parkway  
Snow Hill, NC 28580  
(252) 747-2544

Greene County Department of Social Services  
227 Kingold Blvd., Suite A  
Snow Hill, NC 28580  
(252) 747-5932

Greene County Health Department  
227 Kingold Blvd., Suite  
Snow Hill, NC 28580  
(252) 747-8181

Greene County Transportation  
104 Hines Street  
Snow Hill, NC 28580  
(252) 747-8474

Greene County Senior Center  
104 Greenridge Road  
Snow Hill, NC 28580  
(252) 747-5436