Are You OK? - R.U. OK?

A Special Needs Registry Program

SPECIAL NEEDS REGISTRATION FORM

YOU MAY SUBMIT ONE FORM PER PERSON ELECTRONICALLY
OR YOU MAY PRINT AND MAIL ONE FORM PER PERSON TO:

WILTON TOWN HALL
R.U. OK? PROGRAM
22 TRAVER ROAD
GANSEVOORT, NY 12831

Registrant:

Last Name _____ First Name _____ MI _____

Address _____ City _____ State NY Zip Code 12831

Home Phone _____ Cell Phone _____ E-mail _____

Mailing Address (if different) _____

Full-time Resident? ○ Yes ○ No If No, when are you in Wilton? _____

Gender: ○ Male ○ Female Height _____ Weight _____ Date of Birth _____

Person filling out form if different from Registrant:

Name _____

Address _____

City _____ State _____ Zip Code _____

Relationship to Registrant _____

☐ *Check Box if you want to be listed as an Emergency Contact for the Registrant*

Please list all Medications :

Do you have a Medication List? ☐ Yes ☐ No

Do you have a File/Vial of Life? ☐ Yes ☐ No

Special Equipment Needs *(Please Check all that apply)* :

Is electricity required for any special equipment? ☐ Yes ☐ No

☐ Oxygen ☐ Wheelchair ☐ Cane ☐ Diabetic Monitoring Equipment

☐ Dialysis ☐ Defibrillator ☐ Crutches ☐ Other *(Please list below) :*

☐ Intravenous ☐ Walker ☐ Suction _____

SPECIAL NEEDS REGISTRATION FORM

-Continued from Page 1-

For Office Use Only

Rec'd _____ By _____

○ MAFD ○ WFD

○ New ○ Change

Evacuation Assistance I am Ambulatory

Disability/Condition *(Please check all that apply)* :

☐ Asthma ☐ Diabetic ☐ Mental Disability ☐ Seizures

☐ Blind ☐ Emphysema ☐ Non-Verbal ☐ Stroke

☐ Breathing Problems ☐ Hearing Impaired ☐ Oxygen Required

☐ Cardiac ☐ Hearing/Seeing Eye Dog? ☐ Require Translator *(Please list your spoken language (s) below) :*

☐ COPD ☐ High Blood Pressure

☐ Dementia *(Please state diagnosis)* :

Psychiatric Diagnosis:

☐ Other *(Please list below)* :

Emergency Contact Information

Family *(Not Residing With You)*

Name

Address

Phone Cell Phone

Neighbor

Name

Address

Phone Cell Phone

Caregiver

Name

Address

Phone Cell Phone

Primary Physician

Name

Address

Phone Cell Phone

I certify that the information provided is true and correct to the best of my knowledge and that my participation in this program is entirely voluntary. As a participant in this program, I understand that the Town of Wilton does not guarantee, nor is under any obligation to provide, any services as a result of my submission of this form. I understand that assistance is provided only during emergencies, and that I should make alternative housing arrangements, in advance, in case I cannot return home.

I hereby grant permission for the release of this information to my local emergency services in order to assist them in responding to my needs and requests during this emergency situation. I understand that I, not the Town of Wilton, will be responsible for the costs and charges I incur, associated with emergency and disaster response.

Signature _____ Date _____

Parent/Guardian Signature _____ Date _____