

**MONACA EMERGENCY MANAGEMENT AGENCY  
SPECIAL NEEDS FORM PLEASE PRINT**

<b>PERSONAL INFORMATION</b>		<b>DATE</b>
Last Name	First Name	Date of Birth
Street Address:		Home Phone:
Mailing Address:		Cell Phone:
Primary Language:		
Living Situation: (check one) <input type="checkbox"/> Lives Alone <input type="checkbox"/> Living with Spouse <input type="checkbox"/> With Children <input type="checkbox"/> With Parents <input type="checkbox"/> Other		

<b>MEDICAL INFORMATION</b>	
<input type="checkbox"/> Required or Life-Sustaining Medical Equipment	<input type="checkbox"/> WheelChair Bound
<input type="checkbox"/> Oxygen Concentrator	<input type="checkbox"/> Walker
<input type="checkbox"/> Portable Qxygen	<input type="checkbox"/> Bedridden (Need Stretcher)
<input type="checkbox"/> Nebulizer	<input type="checkbox"/> Hearing Impaired
<input type="checkbox"/> Respirator (Ventilator)	Sign Language: Yes / No
<input type="checkbox"/> Suction Machine	<input type="checkbox"/> Site Impaired
<input type="checkbox"/> Other	<input type="checkbox"/> Seizuries (Explain)

<b>EMERGENCY CONTACT INFORMATION</b>		
First Name:	Last Name:	Relationship:
Home Phone:	Cell Phone:	Other:

<b>SHELTER INFORMATION</b>	<b>PET INFORMATION</b>
Provide Own Transportation to Shelter <input type="checkbox"/> Yes / <input type="checkbox"/> No	Indicate How Many
If you need assistance with transportation, Check one of the following:	_____ Dog (s)
<input type="checkbox"/> Automobile	_____ Cat (s)
<input type="checkbox"/> Van with Wheelchair Lift	_____ Service Dog
<input type="checkbox"/> Ambulance (Patient must initial) _____	_____ Other

**COMMENTS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**AUTHORIZATION INFORMATION:**

I agree that my name be added to the Special Needs List. I give Monaca Emergency Management authorization to share this information with other local support agencies in the event of an emergency nofication and or evacuation. I also grant emergency response personnel permission to enter my home during search and rescue operations following a disaster, if necessary, to assure my safety and welfare.

Patient Signature: \_\_\_\_\_  
 Date: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_  
 Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_  
 Date: \_\_\_\_\_