

Transportation: Do you require transportation? Yes No

If Yes, I require;

Special transportation Vehicle with lift gate Vehicle equipped for stretcher

Ambulance: For Basic Life Support For Advanced Life Support

Medications:

Do any of your medications require refrigeration? Yes No

Medications are: Intravenous Injection By mouth

Do you have a medication list? Yes No

If yes – kept where? _____

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

If yes – kept where? _____

Locations where medicines are kept:

Daily (if in pill container) _____

Actual prescription bottles _____

You may attach a medication list to this form if you wish.

Do you have allergies? Yes No

If yes, please list allergies: _____

Disability/Condition (check all that apply):

Visually impaired Hearing impaired Do you have a hearing/seeing eye dog?

Require Translator (language): _____

Breathing Problems: COPD Asthma Emphysema

Require Oxygen? Occasional or Continuous

Oxygen Supplier _____ Phone No. _____

Mental Disability Dementia Psychiatric Diagnosis Cardiac

Dialysis Seizures Diabetes Stroke Other _____

Special Equipment: Is electricity required? Yes No

Oxygen Dialysis Intravenous Wheelchair Defibrillator

Walker/Cane Crutches Suction Diabetic Monitoring Equipment

Other _____

Emergency Contacts:

Family (not residing with you): Name: _____

Phone _____

Cell Phone _____

Address: _____

Neighbor: Name: _____

Phone _____

Cell Phone _____

Address: _____

Caregiver: Name: _____

Phone _____

Cell Phone _____

Address: _____

Primary Physician Name: _____

Phone _____

Address: _____

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I certify that this information is correct and to the best of my knowledge and that participation in this program is voluntary. I understand that based on the information provided to me, I may or may not be assigned to a special needs unit. The Town of Greenfield is under no obligation to provide any services as a result of my submission of this form. I understand that the assistance will be provided only for the duration of the emergency and that I should make alternate arrangements in advance in case I am not able to return to my home.

I understand that I will be responsible for any charges and costs associated with hospital or other medical facility care or medical transportation. I grant permission to medical providers, transportation agencies, and others, as necessary to provide care and disclose information to respond to my needs. I hereby grant permission for the release of this information to emergency response agencies and pre-authorize these agencies to enter my residence for the purpose of emergency search and rescue.

Signature of Applicant: _____ Date _____

Signature of Legal Guardian _____ Date _____

Signature of Person completing this form other than applicant or legal guardian:

_____	_____	_____
Signature	Relationship to applicant	Date

Please do not write below this line

Fire District _____ Evacuation Level _____ Reviewed by _____