Lenoir County

Department of Emergency Services

Voluntary Special Needs Registry Program

The Lenoir County Emergency Services Department maintains a voluntary People With Special Needs Registry. In the event of severe weather or any type of disaster, this department will attempt to provide special medical sheltering and transportation. If you have a special medical condition requiring medical sheltering and/or transportation, please complete this questionnaire and mail it to the following address:

Lenoir County Emergency Services
PO Box 3289
Kinston, NC 28502

The medical information you provide will only be given to first response agencies associated with your emergency evacuation. This form authorizes emergency response agencies to enter your home for post-disaster search and rescue activities.

You are responsible for any costs associated with medical transportation and/or medical sheltering that are incurred beyond the scope of the emergency event. These costs cannot be assumed by Lenoir County or any of the emergency response agencies.

Due to the time required and limited resources to safely evaluate the people with special needs, the evacuation process is executed well in advance of impending disaster. You must be ready to evacuate when told to do so by emergency officials.

Pets are NOT allowed in evacuation shelters. Please contact Eve Honeycutt with CART (County Animal Response Team) at 252-527-2191. You must make arrangements for your pet's safety in the event of a disaster or emergency.

☐ **I have read and acknowledge the above information**

PO Box 3289 Kinston, NC 28501 • Phone (252) 526-6666 • Fax (252)559-6152
www.lenoircountyemergencyservices.com

Lenoir County

Department of Emergency Services

Citizens With Special Needs Program Registration Form

PO Box 3289 Kinston, NC 28501 • Phone (252) 526-6666 • Fax (252)559-6152
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VOLUNTARY SPECIAL NEEDS REGISTRATION FORM

Name: _____ Date of Birth: _____
Caregiver: _____
Address: _____ Apt/Suite: _____
City: _____ State: _____ Zip: _____

Do you live in a mobile home? ☐ Yes ☐ No
If yes, please provide park name: _____

CHECK ALL APPLICABLE MEDICAL DISABILITIES

Legally Blind ☐ Terminal ☐
Deaf/Hard of Hearing ☐ Contagious Disease ☐
Specify other medical disabilities, i.e. catheter, feeding tube, etc.: _____

Are you :

Self Ambulatory ☐ Ambulatory with assistance ☐
Confined to a wheelchair ☐ Non-Ambulatory ☐

CHECK ANY SPECIAL EQUIPMENT YOU ARE DEPENDENT UPON

Bedridden ☐ Dialysis ☐
Wheelchair ☐ IV ☐
Pacemaker ☐ Insulin ☐
Walker/Cane ☐ Life Support System ☐
Oxygen ☐ # of hours needed daily: _____ Liter flow: _____
If you checked yes to oxygen, is your tank portable? ☐ *Yes* ☐ *No*

Do you have a DNR? ☐ Yes ☐ No
Do you have Advanced Directives? ☐ Yes ☐ No

Registrant's Signature Date

GENERAL PHYSICIAN'S INFORMATION

Name: _____ Phone: _____
Home Health Provider: _____ Phone: _____
Emergency Contact: _____ Phone: _____
Daytime Phone: _____ Evening Phone: _____
Can you get to an Evacuation Shelter? ☐ Yes ☐ No
If no, please check the appropriate transportation needed:
Standard (Bus, Car) ☐ Ambulance ☐ Wheelchair Van ☐
Your Caregiver MUST accompany you to the evacuation shelter.
Please provide their information:
Caregiver Name: _____
Relationship: _____ Phone: _____
Have you made arrangements for any pets? They WILL NOT be allowed at the shelters.

The information contained herein is true and correct to my knowledge. I have read the information on the back of this form and I understand the limitation on the services and level of care available. I understand that assistance will be provided only for the duration of the emergency and that alternative arrangements should be made in advance in the event I am not able to return to my home. I also understand that I will be responsible for any charges and costs associated with the hospital or other medical facility care or medical transport beyond the scope of the emergency. I grant permission to medical providers, transportation agencies, and any others to provide care and disclose information necessary to respond to my emergent needs.

I understand that this registration is voluntary and hereby request registration in the CITIZENS WITH SPECIAL NEEDS REGISTRY PROGRAM.

Registrant's Signature Date

Upon signing this form, I acknowledge that I am informed of the NC Privacy Act (HIPPA)

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