Brooklyn, Ct. Special Needs Emergency Registry

For Brooklyn residents with disabilities, chronic conditions, and special healthcare needs

Brooklyn Emergency Management and Homeland Security Commission maintains a registry for residents with disabilities, chronic conditions, and/or special healthcare needs who live at home or in group homes. By participating in the Registry, you permit BEMHS to share your information with local and state emergency responders, such as your town fire departments. The information that you provide may help responders meet your needs during an emergency, though assistance cannot be guaranteed.

Instructions: To be included in the Registry, please fill out this form, sign it, and send it to: BEMHS Director, 4 Wolf Den Road, P.O. Box 356, Brooklyn, CT. 06234 or place it in a sealed envelope addressed to BEMHS Director and drop it off at the Town Hall.

If you cannot fill out this form on your own, please have a family member, caregiver, or other representative complete the form and submit it on your behalf.

GENERAL INFORMATION: Fields marked with an asterisk(*) are mandatory. Please print clearly.

Name*_____
First Name Middle Name Last Name

Gender*: M F

Date of birth*:_____
(MM/DD/YYYY)

PHYSICAL STREET ADDRESS

Street address*:_____

Apartment unit/floor_____

City/town*:_____

Zip code:_____

MAILING ADDRESS IF DIFFERENT

P. O. Box*:_____

Apartment/unit:_____

City/town*:_____

State:_____ZIP code:_____

CONTACT INFORMATION (*Phone # required)

Home Phone:___(____)_____

Text only number:____(____)_____

Cell Phone:_____(_____)_____

Videophone number:__(____)_____

Email:_____

TTY:_____(____)_____

EMERGENCY CONTACT:

Name:_____

Relationship:_____

Phone:_____

Email:_____

LIVING SITUATION

I live in Brooklyn (check al that apply to you):

_____Seasonally from _____(month) to:_____

_____Year-round

I live in (select one type of housing):

_____Single family house

_____Apartment _____floor

_____Other_____

I live (check all that apply to you):

_____Alone

_____With family/friends

_____With caregiver

_____In a group home operated by_____

_____In an independent senior living facility

_____Other:_____

LANGUAGE: I prefer to communicate in (select one)

_____English

_____American Sign Language

_____Spanish

_____Portuguese

_____French

_____Other:_____

LIFE SUPPORT SYSTEMS: (Check all that apply to you)

_____Oxygen tanks _____I have spares

_____Oxygen concentrator

_____I have battery or generator back up for this

_____Respirator/ventilator

_____I have battery or generator back up for this

_____Tracheostomy

_____IV line

_____Urinary catheters

_____Colostomy/ileostomy

_____Feeding tube

_____Suction tube

_____I have battery or generator back up for this

_____Dialysis at a clinic

_____Dialysis at home

_____I have battery or generator back up for this

_____Pacemaker

_____Defibrillator

_____Other electrical needs:_____

_____None of the above

SENSORY: Check all that apply to you

_____Hard of hearing _____Visually impaired

_____Use of hearing aid(s) _____Legally blind

_____Deaf _____None of the above

_____Use of cochlear implant(s)

COGNITIVE/PSYCHIATRIC/NEUROLOGICAL/ MUSCULAR (Check all that apply to you:)

_____Seizure disorder _____Depression

_____Speech impaired _____Anxiety

_____Non-verbal _____Bipolar disorder

_____Cognitively/ _____Schizophrenia

Developmentally delayed_____Post-traumatic

_____Autism spectrum disorder stress disorder (PTSD)

_____Alzheimer's/dementia _____Obsessive compulsive

_____Parkinson's disorder (OCD)

_____Cerebral palsy _____Other_____

_____Multiple sclerosis _____None of the above

OTHER DISABILITIES/CONDITIONS:

_____Diabetes_____I use insulin

_____I weigh over 300 pounds

Other:_____

_____

MOBILITY: (Check all that apply to you)

_____Use a wheelchair/mobility vehicle

_____The vehicle is power dependent

_____I have battery/generator back up for this

_____Use walker/cane

_____Use crutches

_____Use prosthesis (specify prosthesis):_____

_____Confined to bed

_____Bed is power dependent

_____I have battery/generator back up for this

_____Other:_____

_____None of the above

TRANSPORTATION: (Check all that apply to you)

When I leave my home, I most frequently us a(n):

_____ Personal vehicle

_____Taxi/car service

_____Wheelchair van/bus

_____Ambulance

_____Other:_____

ASSISTANCE REQUIRED: (Check all that apply to you)

On a normal day, I require assistance with:

_____Feeding myself

_____Taking medication(s)

_____Transportation

_____Using the toilet

_____Dressing/undressing

_____Bathing/grooming

_____Transferring from/to:____Bed ____Wheelchair

____Toilet ____Shower/tub

Other assistance:

_____I use a service animal

_____I require supervision

_____I receive medical treatment from a nurse/doctor at home

_____I receive medical treatment at a healthcare facility at least once a week

_____Other_____

NOTE: By signing this form, I agree to permit my information to be shared with local and state emergency responders. I understand that this is a voluntary program and while Brooklyn Emergency Management and Homeland Security will share this information in order to better assist me during an emergency, they cannot guarantee assistance in all cases.

Signature: _____

Print name: _____

Date: _____

If you are completing this form on someone's behalf, please indicate your name and relationship to that individual:

_____