NJ Special Needs Registry Form

Complete this form for you or anyone you know who may need assistance in an evacuation.
This information is strictly **CONFIDENTIAL.**

Personal Information

First Name:_____ MI:___ Last Name: _____

Address:_____

City:_____ State:_____ Zip:_____

County:_____ Municipality:_____

Phone:_____ ☐ TTY Number

☐ Does NOT have a phone E-Mail:_____

Date of Birth: ____/_____/_____ Height: _____ ☐ Weight Over 300 lbs

Emergency Contact Information ☐ I choose not to provide emergency contact information

First Name:_____ MI:___ Last Name: _____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ E-Mail: _____

Relationship to Individual: _____

Duration of Need

Are the person's conditions temporary?

☐ YES (Date condition to be resolved: (___/___/___) ☐ NO, conditions are permanent

Does the person in need have a service animal? ☐ YES ☐ NO

Does the person in need have pets? ☐ YES ☐ NO

Does the person in need have medication that must be taken with them if evacuated? ☐ YES ☐ NO

Does the person in need have a 24 hour care giver? ☐ YES ☐ NO

Does the person in need require evacuation assistance 24/7? ☐ YES ☐ NO

I need assistance from ____:____ AM/PM ____:____ AM/PM

Is the person in need a temporary resident? ☐ YES ☐ NO

I am a resident from _____(month) to _____(month)

Evacuation Information

- ☐ Sight Impaired
- ☐ Hearing Impaired
- ☐ Speech Impaired
- ☐ Physically Impaired
- ☐ Completely Bedridden
- ☐ Mentally / Memory Impaired
- ☐ Dementia / Alzheimer's
- ☐ Dialysis
- ☐ Requires Skilled Nursing
- ☐ Other: _____

Does not:

- ☐ Have Access to a Car
- ☐ Have a Radio
- ☐ Have a Television

- ☐ Does Not Speak English

Primary Language: _____

Requires:

- ☐ Wheelchair
- ☐ Motorized Wheelchair
- ☐ Walker / Cane
- ☐ Assistant / Care Giver
- ☐ Oxygen or Concentrator Cylinder
- ☐ Ventilator
- ☐ Suction Machine
- ☐ Other Equipment: _____
- ☐ **I am HOMEBOUND**