



# JO DAVIESS COUNTY HEALTH DEPARTMENT

9483 US RT. 20 West · PO Box 318 · Galena, IL 61036 · (815) 777-0263

[www.jodavieess.org/publichealth](http://www.jodavieess.org/publichealth)

Emergency/Special Needs Registration Form Page 1 of 2

**Disclaimer:** This form is intended to direct help to you from the police and fire department in the event of an emergency, based on any extra needs you may have.

**Agency Affiliations:** (i.e., Home Health, Medical Equipment, Dialysis Center, Mental Health, Other)

Last Name	First Name	MI	Birthdate (MM/DD/YY)	Sex (M/F)
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**Ethnicity (Check One)**

- |  |  |                                     |
|--|--|-------------------------------------|
| <input type="checkbox"/> African American          | <input type="checkbox"/> Caucasian (White)                 | <input type="checkbox"/> Hispanic   |
| <input type="checkbox"/> Asian or Pacific Islander | <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Mixed Race |
| <input type="checkbox"/> Other                     | <input type="checkbox"/> Unspecified                       |                                     |

Street Address	Apt #	City	Zip-Code
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Mailing Address (if different)	Apt #	City	Zip-Code
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Home Phone Number - - - - -	Work Phone Number - - - - -	Cell Phone Number - - - - -
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## Medical Information (Check and complete those that apply to your situation.)

- |  |  |
|--|--|
| <input type="checkbox"/> Required or Life-Sustaining Medical Equipment<br><input type="checkbox"/> Oxygen Concentrator <input type="checkbox"/> Respirator / Ventilator<br><input type="checkbox"/> Portable Oxygen <input type="checkbox"/> Suction Machine<br><input type="checkbox"/> Nebulizer <input type="checkbox"/> Other: _____<br><br><input type="checkbox"/> Oxygen Continuous<br>Amount of Oxygen? _____<br><br><input type="checkbox"/> Oxygen Treatments Only<br>Amount of Oxygen? _____<br>How Often? _____<br><br><input type="checkbox"/> Oxygen PRN (As Needed)<br>Nighttime (# of Hours) _____<br>Daytime (# of Hours) _____<br>Amount used per day? _____<br><br><input type="checkbox"/> Cardiac History <input type="checkbox"/> Dialysis    How Often? _____<br><input type="checkbox"/> Incontinent <input type="checkbox"/> Frail<br><input type="checkbox"/> Mobility Impaired (Explain) _____<br><br><input type="checkbox"/> Life Sustaining Medications: _____ | <input type="checkbox"/> Wheelchair Bound<br><input type="checkbox"/> Bedridden<br><input type="checkbox"/> Weight above 300lbs<br><input type="checkbox"/> Hearing Impaired<br><input type="checkbox"/> Sight Impaired<br><input type="checkbox"/> Speech Impaired<br><input type="checkbox"/> Memory Impaired<br><input type="checkbox"/> Anxiety<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Emergency Alert Equipment<br><br><input type="checkbox"/> Mental Health Impaired (Explain)<br>_____<br><br><input type="checkbox"/> Allergies (Explain)<br>_____<br>_____<br><br><input type="checkbox"/> Other (Explain)<br>_____<br>_____ |
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Emergency/Special Needs Registration Form Page 2 of 2

## Emergency Contact Information

First Name:	Last Name:	Relationship:	Phone: ____ - ____ - ____
First Name:	Last Name:	Relationship:	Phone: ____ - ____ - ____

## Additional Comments

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## Authorization Information

### OPTIONAL: PREAUTHORIZATION TO ENTER HOME BY EMERGENCY PERSONNEL

I authorize emergency response people to enter my home during search and rescue operations following a disaster, if necessary, to assure my safety and welfare.

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

I, (Print Name) \_\_\_\_\_

Understand that all of my medical records are confidential and are not to be disclosed to anyone without my consent.

I hereby provide my consent for first responders (police / fire) to have access to the medical information contained on this form for the purposes of rescuing me in the event of an emergency.

I further understand that only those persons who have a need to know this information will have access to it. This release remains in effect until further notice unless revoked by me in writing.

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

Print Name of Person Completing This Form if Other Than Client:	Phone: ____ - ____ - ____
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***Please complete both pages of the following registration form and mail to the address at the top; or fill out the form online.***