ATTACHMENT 1
**Lincoln Trail District Health Department**  
P.O. Box 2509  
108 New Glendale Road  
Elizabethtown, KY 42702  
(P) 270-765-1601, (I) 270-765-7274

**Special Needs Registry**  
**Registration Form**  
*(PLEASE PRINT)*

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
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<tr>
<th>Address</th>
<th>Apt. #</th>
<th>County</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<tr>
<th>Phone/TTY</th>
<th>Email</th>
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**Gender:**  
☐ Male  ☑ Female  
**Date of Birth** __/__/____  
**Weight** __________

**Number of relatives living with you who will accompany you to a shelter if need be:** __________

**Emergency Contact Information**

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number (______)</th>
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<table>
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<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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**Residence Type:**  
☐ Private Home  ☑ Apartment/Condo  ☑ Mobile Home  ☑ High-Rise  ☑ Group Home  
☐ Assisted Living  ☑ Duplex  ☑ Dorm  ☑ Other __________

**Name of complex/subdivision:** __________

**Year-round resident?**  
☐ YES  ☑ NO  
**If no, from** __________ to __________

**Do you have pets?**  
☐ YES  ☑ NO  
**If yes, what type and how many** __________

**Do you have arrangements for them in an emergency?**  
☐ YES  ☑ NO  
*(Please be advised that pets may NOT accompany you to a shelter unless they are companion/service animals)*

**Evacuation Information**

**Will you require evacuation assistance?**  
☐ YES  ☑ NO  

**Do you:**  
☐ Care for yourself  ☑ Regularly have assistance from a caregiver

<table>
<thead>
<tr>
<th>Name of caregiver</th>
<th>Phone Number (______)</th>
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<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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</table>

**Transportation**  
*(Check all that apply)*

☐ I will provide my own transportation  
☐ I can get to a bus pickup point  
☐ I need a wheelchair lift equipped vehicle  
☐ I am ambulatory with no assistance  
☐ I am ambulatory with assistance  
☐ I am bedridden and require stretcher transport  
☐ I can transfer from a wheelchair to a seat

**Special Equipment**  
*(Check all that apply)*

☐ Wheelchair dependent  
☐ Walker/Cane  
☐ Medical Equipment Requiring Electricity, type __________  
☐ Oxygen Dependent  
☐ Other (please describe) __________

**Type of Disability/Special Need**  
*(Check all that apply)*

☐ Deaf/Hearing Impaired  
☐ Blind/Visually Impaired  
☐ I have hearing/seeing service animal which will accompany me  
☐ Mental Disability  
☐ Bedridden  
☐ Alzheimer's  
☐ Developmental Disability  
☐ Other: __________
**Is Your Disability/Special Need:** □ Temporary   OR   □ Permanent
If temporary, please give a medical release date
NOTE: unless you notify registry personnel, you will be deleted from registry as of the above date.

**What illness do you take medication for:** (check all that apply)

<table>
<thead>
<tr>
<th>ILLNESS</th>
<th>MEDICATION(S) TAKEN</th>
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<tbody>
<tr>
<td>□ Heart problems</td>
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<td>□ Blood pressure</td>
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<td>□ Stroke</td>
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<tr>
<td>□ Diabetes</td>
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<td>□ Breathing problems, Type</td>
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<td>□ Back problems</td>
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<td>□ Seizures/convulsions</td>
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<td>□ Contagious disease, Type</td>
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<td>□ Behavioral Health</td>
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<td>□ Arthritis/Osteoporosis</td>
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<td>□ Cancer, Type</td>
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<td>□ Dialysis, number of times per week</td>
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<td>□ Other</td>
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<td>□ Allergies to any medicines, list</td>
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Do you require a special diet? □ YES   □ NO  If yes, what type?

Name of Family/Primary Care Physician: ___________________________ Phone Number (_______)

Do you have any other comments or suggestions that may assist us in your care during an emergency/disaster? ___________________________

Completing this registration form DOES NOT create a contract for services. Neither the entities or individuals that have created or maintained this registry or collected information for this registry, nor any entity or individual that may utilize the information contained in the registry including but not limited to Lincoln Trail District Health Department, Commonwealth of Kentucky, its Cabinets, Departments, or Associations, emergency personnel and volunteers, warrant that assistance will be provided to you during an emergency or disaster.

Participation in this registry is voluntary. It is your duty and responsibility to update your information on this registry. By completing this registration form you hereby confirm and attest that the information provided in this registration is correct and that should the information that you have provided change, you will promptly update the registry. By completing this registration form, you also hereby warrant that the information you have provided has been provided voluntarily and that if you have required assistance to complete this form that you have consented to the assistance provided. By completing this registration form you also hereby waive any and all claims which relate to the collection, maintenance or use of the information you have supplied which may be asserted against the entities or individuals that have created or maintained this registry or collected information for this registry and any entity or individual that may utilize the information contained in the registry including but not limited to Lincoln Trail District Health Department, Commonwealth of Kentucky, its Cabinets, Departments, or Associations, emergency personnel and volunteers.

Registrant’s Signature: ___________________________ Date: ____________
If caregiver provided information or completed registration form on behalf of registrant -
Caregiver Name: ____________________________________________
Caregiver’s Signature: ___________________________ Date: ____________
Relationship to Registrant (if any)

Please mail form back to: Lincoln Trail District Health Department
MRC Coordinator
P.O. Box 2609
Elizabethtown, KY 42702
**PERSONAL INFORMATION**

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Mid Initial</th>
<th>Date of Birth</th>
<th>Male</th>
<th>Female</th>
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<tr>
<th>Street Address</th>
<th>City</th>
<th>Lexington</th>
<th>Zip</th>
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If temporary address, give dates: From _____________ To _____________

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<tr>
<th>Flood Prone Area</th>
<th>Yes</th>
<th>No</th>
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<th>Mailing Address</th>
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<th>Lexington</th>
<th>Zip</th>
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<th>Home #</th>
<th>Cell #</th>
<th>Work/Alt #</th>
<th>Phone/TTY #</th>
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**Residence:**
- Single Family
- Multi-Story
- Long Term Care
- Mobile Home

**Living Situation:**
- Alone
- With Spouse
- With Caregiver
- Caregiver name/relationship: _____________

# of Dependents less than 18 years old: _____________

# of Dependents 18 years and older: _____________

**Primary Language**
- Require a translator
- Yes
- No
- If so, what language _____________

**Email Address**
- Alternate Email Address

**Pets:**
- Dog(s) _____________
- Cat(s) _____________
- Service Animal (Type) _____________
- Other (Type) _____________

**MEDICAL INFORMATION**

**Condition/Disability**

If temporary condition, give dates From _____________ To _____________

**Medications (prescription, over-the-counter, and herbal):**

<table>
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<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>How Often</th>
<th>Needs Refrigeration</th>
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<tr>
<td>Medication Name</td>
<td>Dose</td>
<td>How Often</td>
<td>Needs Refrigeration</td>
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If you need to list more medications, record the information on an separate piece of paper.

Home Health Agency
Medical Equipment Supply Co.
Dialysis Center

Other Agency Affiliations (i.e., Hearing, Visual, Developmental, Mental Health Services, Other Special Services)

Dialysis:  
- Home  
- Center  
Times dialyzed per week

**OXYGEN REQUIREMENTS:**

- Concentrator  
- Respirator (Ventilator)  
- Portable  
- Suction Machine  
- Nebulizer  
- Other

Oxygen Frequency:  
- Continuous  
- Treatments Only  
- PRN (As Needed)

Nighttime # Hrs  
Daytime # Hrs  
Amt used in 24 hrs  
How often

**ADDITIONAL MEDICAL INFORMATION:**

Height  
Weight  
Paralysis:  
- Complete  
- Partial

Pregnant  
Due Date  
High Risk?  
- Explain

Open wounds that require dressing changes  
How often

- Sight Impaired  
- Glasses  
- Contacts  
- Hearing Impaired  
- Hearing Aid

- Memory Impaired  
- Mobility Impaired  
- Speech Impaired  
- Dentures  
- Diabetes

- High Blood Pressure  
- Severe Arthritis  
- Anxiety/Depression  
- Heart Condition  
- Cardiac History

- Life-sustaining Medications  
- Frail  
- Wheelchair Bound  
- Bedridden  
- Incontinent

- Emergency Alert Equipment  
- DNR Order (if so, attach copy)  
- Required or Life-Sustaining Med Equip.
Mental Health Impaired (Explain)

Special Dietary Needs (Explain)

Contagious/Infectious Disease (Explain)

Other Issues (Explain)

Allergies (Medical and Non-Medical)

EMERGENCY CONTACT INFORMATION

First Name    Last Name    Relationship    Phone:

First Name    Last Name    Relationship    Phone:

PHYSICIAN/PHARMACY INFORMATION

Primary Care Provider    Provider Phone:

Pharmacy Name    Pharmacy Phone:

TRANSPORTATION INFORMATION

Do you need assistance to evacuate your dwelling in an emergency?    □ Yes    □ No

Can you provide your own transportation to a shelter?    □ Yes    □ No

If you will need transportation assistance, check the type you will need:

□ Automobile    □ Van with wheelchair lift    □ Stretcher    □ Ambulance (patient must initial) **

** (Note: if ambulance is requested, patient will be responsible for transportation costs of ambulance.)

APPLICANT REPRESENTATIVE

If the person completing this form is not the applicant, please answer the following:

Name    Relationship/Agency

Applicant has been notified of this registration?    □ Yes    □ No

Sign    Date

PRIVACY STATEMENT

We respect your right to confidentiality and continuously take every possible measure to ensure that your personal information remains confidential. We do not collect or maintain information about you that is not essential for your safety and well-being.

All employees of the Lexington-Fayette County Health Department and the Lexington Fayette Urban County Government Division of Environmental and Emergency Management are required to adhere to this privacy statement of confidentiality and nondisclosure.
AUTHORIZATION INFORMATION

I authorize emergency response personnel to enter my home during search and rescue operations following a disaster, if necessary, to assure my safety and welfare. I grant permission to medical providers, transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs.

I hereby provide my consent for the members of the Lexington-Fayette County Health Department and the Lexington Fayette Urban County Government Division of Environmental and Emergency Management to have access to the medical information contained in this form. 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.

I agree that my name be added to the Special Needs Emergency Shelter Registry. I understand that this form is not a reservation for the Special Needs Shelter, but that my medical information will be used to determine/assess plans appropriate for my care and treatment during an emergency.

I understand that the Special Needs Shelter may not be air conditioned if emergency power is required. I understand that I need to bring with me all medications, in marked bottles, and all medical supplies I use for my care for up to 7 days (one week).

To the best of my knowledge, I certify that this information contained herein is true and correct. I understand that based on this application and the data I have provided, the Division of Environmental and Emergency Management will determine which emergency evacuation assistance, if any, this program may be able to provide.

Sign __________________________ Date __________________________

☐ Check if you are an organ donor

Please sign and mail to:
DEEM, 166 N Martin Luther King Blvd, Lexington, KY 40507
or fax to 859-252-8689.
SPECIAL NEEDS REGISTRY INFORMATION

If you or other members of your household would require special assistance in the event of an emergency evacuation, please complete this form or call 2-1-1 to register over the phone, so that special arrangements can be made in advance. This information will be kept confidential and will be forwarded to state and local emergency responders in Woodbury County.

NAME ___________________________ D.O.B __/__/____
PHONE: ___________________________ ADDRESS ___________________________

CITY _____________________________ STATE ______________ ZIP ______________
LOT# _____________________________ APT # __________________________

TYPE OF DWELLING: APARTMENT COMPLEX CONDO DUPLEX
PRIVATE HOME GROUP HOME

NUMBER OF RESIDENTS IN HOME ___________________________
LANGUAGE SPOKEN IN THE HOME ___________________________

FULL-TIME RESIDENT (yes ___ no ___)
PART-TIME RESIDENT / WHICH MONTHS LIVING AT THIS RESIDENCE ___________________________

EMERGENCY CONTACT (NOT LIVING WITH YOU):
PHONE ___________________________
ADDRESS ___________________________
CITY _____________________________ STATE ______________ ZIP ______________
RELATIONSHIP ___________________________

OUT OF CITY CONTACT ___________________________
PHONE ___________________________
ADDRESS ___________________________
CITY _____________________________ STATE ______________ ZIP ______________

IF YOU GO TO A SHELTER, WHO WILL BE STAYING WITH YOU?
PHONE ___________________________

PHYSICIAN NAME ___________________________
HOME HEALTH AGENCY ___________________________
PHONE ___________________________

SUBSCRIBE TO LIFELINE OR OTHER EMERGENCY NOTIFICATION SYSTEMS:
YES ___ NO ___

CITIZEN MOBILITY

____ Can walk ________ needs assistance
____ Wheel Chair If so, do you have your own? Y N
____ Bedridden If so, can you be moved by wheelchair? Y N

TRANSPORTATION INFORMATION

If, in an emergency situation, you were instructed to leave your home and move to an emergency shelter, how would you get there?
____ Your own car ________ Neighbor ________ Do not have a way

TRANSPORTATION NEEDS

____ Ambulance ________ Van with wheelchair lift ________ Walker Assistance
____ Regular car or van ________ Other ________
MEDICAL INFORMATION:
Please check all disabilities that you have.

___ Hearing impaired  TTD?  Y N
___ Blind  Guide Dog?  Y N

___ Do you use electrically dependent life support systems?
   Oxygen Supported?  L/min   ___________ Tank   _______ O2 Converter   _______

___ Does anyone in this home have any special issues that may prevent them from
   leaving the home during an emergency or stressful situation?  YES  NO

Please explain:  __________________________________________________________________________

PET INFORMATION

___ Do you have a pet?  Y  N
If so, what kind?  Dog  Cat
Other  ____________________________________________

___ Is this a service animal?  Y  N

___ Have you made arrangements for sheltering your pet?  Y  N
What are the arrangements?  __________________________________________________________

RELEASE OF INFORMATION

I, ____________________________________________________________, GIVE MY AUTHORIZATION FOR
THE MEDICAL INFORMATION CONTAINED HEREIN TO BE RELEASED TO THE
EMERGENCY SERVICES PERSONNEL AND SIOUXLAND DISTRICT HEALTH
DEPARTMENT. I UNDERSTAND THAT THIS INFORMATION WILL BE USED FOR THE
PURPOSE OF EVALUATING MY NEEDS IN A TIME OF AN EMERGENCY AND WILL
BE MAINTAINED AS CONFIDENTIAL. I PROVIDE THIS INFORMATION ON A
VOLUNTEER BASIS.

SIGNATURE: ____________________________________ DATE: __/__/____

MAILING ADDRESS  

CITY________________________ STATE_______ ZIP________

WITNESS: __________________________ DATE __/__/____

OFFICE USE ONLY

Date Survey Completed: _________________ Incident #____________

Date  District #  Map Reference  Initial

CAD: ____________ _________ _________

RTE: ____________ _________ _________