

Emergency Evacuation/ Special Needs Registration

Madison County EMC

101 W. Main, Suite B-13

Madisonville, Tx 77864

(936-)348-3810

A. Personal Information

1. Name: _____ Spouse: _____
2. Home Address: _____ Apt #: _____
City: _____ County: _____ Zip Code: _____
3. Mailing Address: _____
City: _____ County: _____ Zip Code: _____
4. Work Location: _____ Room #: _____
City: _____ County: _____ Zip Code: _____
5. Home Phone: _____ Cell Phone: _____ Work Phone: _____
6. Name of Complex/ Subdivision: _____ Email: _____
7. Do you have any pets? Yes ___ What type _____ No ___

B. Medical Information

1. Are you a Hospice Patient? Yes: _____ No: _____
(If yes, include a copy of your physician's "No-Code" with this form)
2. Please describe your medical disability: _____

3. Do you: Care for yourself ___ Have caretaker ___ Need assistance ___ Hrs./day ___
4. Name of Caretaker: _____ Phone: _____
5. Are you ambulatory? With assistance _____ Without assistance _____
6. Are you confined to a bed? Yes _____ No _____ Occasionally _____
7. Do you use a wheelchair? Yes _____ No _____ Occasionally _____
8. Do you use a walker or cane? Yes _____ No _____ Occasionally _____
9. Are you on life - support system requiring electricity? Oxygen ___ Respirator ___
Suctioning _____
10. If you use oxygen, how many hours do you use it per day? _____
11. Do you have a portable oxygen tank? Yes _____ No _____
12. Do you require a special diet? Yes _____ No _____ Occasionally _____
13. If yes, what type? _____
14. Are you allergic to any medications or foods? Yes _____ No _____
15. If yes, please list: _____
16. Please tell us about your special needs (check any item applicable):
 - a. Oxygen therapy _____
 - b. Life support equipment _____
 - c. Ostomy management _____
 - d. Indwelling catheter _____
 - e. Bedridden _____
 - f. Heavy medication use _____

- g. Terminally ill _____
- h. Shots or IV therapy _____
- i. Frequent dressing changes (at least daily) _____
- j. Dependent on others for care and assistance _____
- k. Unstable medical condition; needs regular nursing or monitoring (specify) _____
- l. Other _____

17. Please list the types of disposable medical supplies you use on a:

- a. Daily basis: _____
- b. Weekly basis: _____

18. Please list all of your medications with dosage below:

C. Evacuation Information

1. If you were to evacuate, where would you stay? Relatives _____ Friends _____
Hotel _____ Shelter _____
2. If shelter, then type of shelter requested: Standard _____ Special Needs _____
3. Name of your physician: _____ Phone _____
4. Nearest relative or friend to contact in case of an emergency:
Name: _____ Phone: _____
5. How many people will evacuate with you? _____

Do you have any other comments or suggestions that may assist us in your care during an evacuation? _____

The undersigned grants permission for Emergency Management to release this information to emergency response agencies

Signature Date

Please return this form or mail this form in the attached envelope to Madison County emergency management office- (look at return address on envelope)

You will be contacted by phone or E-mail by a member of the emergency services staff to review your application and answer any questions you may have. Please contact your Madison County emergency management in the event any of the above information changes at any time (936-348-3810). An annual review of our Disaster Registry will be conducted each year to update our records.

If you are assisting the person filling out this form, please answer the following:

Name: _____ Phone: _____
Agency: _____ Citizen notified of registration: Yes _____ No: _____ Date: _____