Special Needs Registry

This form should only be completed if you have a disability that could hinder emergency care.

Date:

Part One – General

Last Name _____ First Name _____ MI _____ Telephone# (V/TTY) _____

Street Address _____ Apt. # _____ City _____ Zip _____

Date of Birth _____

Does the registrant speak English? ☐ Yes ☐ No If no, language spoken: _____

Location of bedroom (circle one) NE, NW, SE, or SW corner of home. What level is bedroom on?

☐ Basement ☐ Ground Floor ☐ Second Floor Other: (explain) _____

Any additional Telephone Numbers within the residence? _____

Guardian Information

Do you have a legal guardian? ☐ Yes ☐ No If yes, provide contact information for guardian:

Name _____

Address _____ Telephone _____

City _____ State _____ Zip Code _____

Type of Guardianship _____ Date _____

Emergency Contact Information

Name _____ Relationship _____

Address _____ Telephone _____

City _____ State _____ Zip Code _____

Other Emergency Contact _____ Telephone _____

Part Two – Disability

☐ Neurological Impairment ☐ Mobility Impairment (ex: needs assistance, paraplegic, quadriplegic)

☐ Mental Impairment ☐ Blind, Hearing or Speech Impaired (circle)

***You must have checked a box in Part Two in order to continue to Part Three**

Part Three – Medical ***Continue ONLY if you checked a box in Part Two!**

Please check all that apply:

Alzheimer's – Note State		NG tube/CV infusion site/tracheotomy	
Ameliorating Lateral Sclerosis ALS		Insulin	
Asthma		I.V. Medication	
Back Injury		Oxygen	
Cerebral Palsy		Respirator	
Contagious Disease – Specify (ex:HIV/AIDS, Hepatitis)		Non-Ambulatory	
Developmental Disability - Specify		Walker / Cane / Crutches	
Epilepsy / Other Seizures – Specify		Wheelchair User	
Fractured Bones with Pin Care		Wheelchair on occasion	
Full Paralysis		Ambulatory (can get around on your own)	
Heart Condition		Ambulatory with assistance	
Mental Illness – Specify (ex: Bipolar, Schizophrenia, Psychotic, Delusional, Tourette's)			
Severe Arthritis		Terminal Condition	
Stroke – Specify (ex: r. side weakness)		Additional Information	
Wt. Over 250 lbs			
Other Condition – Specify:			

Part Four - Signature

Please notify the Springfield Center for Independent Living at 217-523-2587 (V/TTY) if you need this information in an alternative format, such as Braille or Large Print. If you need help filling out the form call Fran Fulscher, Logan County ETSB at 217-735-3080 (home)

It is your responsibility to update all information when factors change or every two years, whichever is earlier. Changes in information are to be in writing and mailed to:

Logan County Emergency Telephone Systems Board (ETSB)
911 Pekin Street
Lincoln, IL 62656

Signature	Individual	Date
Signature	Relationship to Individual	Date

NOTE: Your information will not be entered without the signed disclosure and this form.

Revised 7/1/2010