Shenandoah County Department of Fire and Rescue Special Needs Registry

Please fill out this form to the best of your knowledge and mail it to the following address:

Shenandoah county Department of Fire and Rescue
600 North Main Street, Suite 109
Woodstock, VA 22664

Phone: 540-459-6167
Fax: 540-459-6192
Email: swalters@shenandoahcountyva.us

General Information

Full Name: _____

Email Address: _____

Gender: ☐ Male ☐ Female

Primary Language: ☐ English ☐ Spanish ☐ Other

Primary Phone Number: _____

Primary Phone Type: ☐ TTY ☐ Text ☐ Relay ☐ Voice

Secondary Phone Number: _____

Secondary Phone Type: ☐ TTY ☐ Text ☐ Relay ☐ Voice

Preferred Contact Method: _____

Date of Birth: _____

Street Address: _____

City/State/Zip: _____

What is your residence type: ☐ House ☐ Apartment ☐ Other

Is there an elevator for use at your residence: ☐ Yes ☐ No

If married, name of Spouse: _____

Is the spouse registered: _____

Personal Information

Do you have a Service Animal: ☐ Yes ☐ No

Weight of Service Animal in pounds: _____

Do you have other Pets: _____

Do you have a caregiver or attendant: ☐ Yes ☐ No

Who is your Home Health Agency: _____

Do you plan to go to a Shelter if told to evacuate: ☐ Yes ☐ No

Do you have a generator? ☐ Yes ☐ No

Do you have an emergency plan? ☐ Yes ☐ No

Physical Considerations:

☐ Bladder ☐ Cognitive Disorder ☐ Mental Condition
☐ Seizures ☐ Bowel ☐ Cardiac Condition
☐ Pulmonary ☐ Weigh over 300 lbs

Do you have other physical considerations:

Do you use any of the following:

☐ Apnea Monitor ☐ Nebulizer ☐ Catheter ☐ Oxygen
☐ CPAP ☐ Electricity ☐ G or J tube ☐ Hospice Care
☐ Insulin ☐ Special Diet ☐ IV Therapy ☐ Tracheotomy
☐ Wound Dressing ☐ Dialysis ☐ Suctioning ☐ Ventilator
☐ Pacemaker ☐ Colostomy ☐ Prescription Meds

Do you use any other Medical or Therapeutic Items:

Mobility Items:

☐ Ambulatory ☐ Power chair or Scooter
☐ Ambulatory with help ☐ Walker/Can/Crutches
☐ Manual Wheelchair ☐ White Cane

Do you have other mobility considerations:

Do you require assistance with:

☐ Bathing ☐ Feeding
☐ Getting Dressed ☐ Visual or other Guidance
☐ Communication ☐ Use of Toilet
☐ Getting in and out of a vehicle ☐ Getting in and out of bed
☐ Climbing Stairs

Height: _____ Weight: _____

Please tell us about any medical condition you may have:

	Check all that apply
No disabilities	☐
Alzheimer's	☐
Back Injury	☐
Blind, hearing impaired or speech impaired	☐
Cerebral Palsy	☐
Contagious Disease – Please specify	☐
Full Paralysis	☐
Heart Condition	☐
High Blood Pressure	☐
Mental Illness – Please specify	☐
Special Diet – Please specify	☐
Other condition – Please Specify	☐

Please tell us about any medication you take:

Name of medication	Dosage	Name of medication	Dosage

Do you have a "Do Not Resuscitate Order"? ☐ Yes ☐ No

If yes, please attach a copy.

Transportation Information

Do you have access to private transportation: ☐Yes ☐No

Can you ride a regular bus with no lift: ☐Yes ☐No

Do you require an ambulance for transportation: ☐Yes ☐No

Do you have other restrictions/comments:

Emergency Contact

Primary Physician:

Physician's Phone:

Primary Emergency Contact

Name:

Phone:

Phone Type: ☐TTY ☐Text ☐Relay ☐Voice

Alternate Phone:

Alternate Phone Type: ☐TTY ☐Text ☐Relay ☐Voice

Address:

City/State/Zip:

Secondary Emergency Contact

Name:

Phone:

Phone Type: ☐TTY ☐Text ☐Relay ☐Voice

Alternate Phone:

Alternate Phone Type: ☐TTY ☐Text ☐Relay ☐Voice

Address:

City/State/Zip: