

**Jackson County Special Needs Registry Application**

**Disclaimer**

The purpose of the Jackson County Special Needs Registry is to provide emergency responders in Jackson County with important information from individuals who may require assistance during an emergency, such as tornado, flood, blizzard, power outage or disease outbreak. This program is voluntary and in no way ensures that the individual completing this form will receive immediate or preferential treatment in an emergency. This program will merely provide the emergency response community with information that is pertinent to developing an effective response. The Jackson County Special Needs Registry in no way replaces the responsibility of individuals to have their own emergency plan.

**Personal Information**

<b>Date of Application:</b>	<input type="checkbox"/> <b>New Application</b> <input type="checkbox"/> <b>Update of Previous Application</b>			
<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>Date of Birth:</b>	<b>Sex:</b>
<b>Street Address:</b>	<b>City:</b>	<b>Zip:</b>	<b>Primary Phone #:</b>	
<b>Mailing Address (If different):</b>	<b>City:</b>	<b>Zip:</b>	<b>Alternate Phone #:</b>	
<b>Name of Subdivision, Mobile Home Park, Apartment Building, etc.:</b>		<b>Primary Language:</b>		
<b>Living Situation (check one):</b> <input type="checkbox"/> Live Alone <input type="checkbox"/> With Spouse <input type="checkbox"/> With Children <input type="checkbox"/> With Parents <input type="checkbox"/> Other ( <i>Explain</i> )				

**Medical Information** (*Check and complete those that apply to your medical condition.*)

<input type="checkbox"/> <b>Wheelchair Bound</b> <input type="checkbox"/> <b>Walker</b> <input type="checkbox"/> <b>Bedridden</b> <input type="checkbox"/> <b>Hearing Impaired</b> <input type="checkbox"/> <b>Sign Language</b> <input type="checkbox"/> <b>Visually Impaired</b> <input type="checkbox"/> <b>Seizures</b> <input type="checkbox"/> <b>Speech Impaired</b> <input type="checkbox"/> <b>Memory Impaired (Explain)</b> <input type="checkbox"/> <b>Ostomy Care</b> <input type="checkbox"/> <b>G-tube Feeders</b> <input type="checkbox"/> <b>Developmentally Disabled:</b>	<input type="checkbox"/> <b>Mental Health Condition</b> <input type="checkbox"/> <b>Special Dietary Needs</b> <input type="checkbox"/> <b>Required or Life-Sustaining Equipment</b> <input type="checkbox"/> <b>Portable Oxygen Machine</b> <input type="checkbox"/> <b>Suction Machine</b> <input type="checkbox"/> <b>Oxygen Concentrator or Ventilator</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Continuous</li> <li><input type="checkbox"/> Intermittent</li> </ul> <input type="checkbox"/> <b>Life Sustaining Medications</b> <input type="checkbox"/> <b>Physically Disabled</b> <input type="checkbox"/> <b>Other (Explain)</b>
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**Explain any that have been checked above including listing any types of diagnosis, medication, etc.:**

**Emergency Contact Information**

<b>Primary Emergency Contact</b>			
<b>Last Name</b>	<b>First Name</b>	<b>Relationship</b>	<b>Phone</b>
<b>Alternate Emergency Contact</b>			
<b>Last Name</b>	<b>First Name</b>	<b>Relationship</b>	<b>Phone</b>

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**Medical Provider Information (Fill in all that apply)**

<b>Physician Name:</b>	<b>Phone:</b>
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<b>Pharmacy Name:</b>	<b>Phone:</b>
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<b>Home Health Care Agency Name:</b>	<b>Phone:</b>
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<b>Shelter Information</b>	<b>Pet Information</b>
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Can you, a family member or friend provide you with transportation to a shelter in an emergency?  
 Yes    No

If you need assistance with transportation, check one of the following:

Automobile                       Van with wheelchair lift  
 Bus                                       Medical transport required

Do you have pets that would require special attention if you were asked to evacuate your home? If so, indicate the number of:

\_\_\_\_\_ Cat                                      \_\_\_\_\_ Dog  
\_\_\_\_\_ Service Dog                                      \_\_\_\_\_ Other (Explain)

**Applicant Additional Comments**

**Authorization Information**

By signing / submitting this form, I / legal guardian agree that my name be added to the Jackson County Special Needs Registry. I give Jackson County Emergency Management authorization to share this information with other community emergency responders in the event of an emergency in order to facilitate an effective response. I grant emergency responders permission to enter my home following an emergency event or disaster situation, if necessary, to assure my safety and welfare.

<b>Applicant Signature</b>	<b>Date</b>
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<b>Authorized Guardian Signature</b>	<b>Date</b>
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**Mail Completed Form to:**

**Jackson County Emergency Management  
30 North 3<sup>rd</sup> Street  
Black River Falls, WI 54615**

For questions regarding this form or this program, contact the Jackson County Emergency Management Office at 715-284-0263 or by email at [john.ross@co.jackson.wi.us](mailto:john.ross@co.jackson.wi.us) When available, this form can be filled out on-line at [www.co.jackson.wi.us](http://www.co.jackson.wi.us)

