# Functional Needs Registry Enrollment Form

**Mail completed Enrollment Form to Region 44 Emergency Management PO Box 666 Fullerton, NE 68638 or email to region44em@hamilton.net.**

Serving Boone, Merrick, & Nance Counties

## I. Identifying Information

Last:_____ First: _____Middle Initial:___

Gender: ☐ Male ☐ Female Date of Birth: ____/_____/_____

Address: _____

City :_____ County:_____

Zip:_____

Phone: Work:_____ Home:_____

Cell:_____ Email: _____

## II. Emergency Contacts

Primary Contact

Name:_____

Relationship: ☐ Family ☐ Friend ☐ Caregiver ☐ Neighbor ☐ Legal Guardian ☐ Other or ☐ Organization,

Specify:_____

Phone: Work:_____ Home:_____

Cell:_____ Email: _____

Secondary Contact

Name:_____

Relationship: ☐ Family ☐ Friend ☐ Caregiver ☐ Neighbor ☐ Legal Guardian ☐ Other or ☐ Organization,

Specify:_____

Phone: Work:_____ Home:_____

Cell:_____ Email: _____

## III. Evacuation

If a local emergency requires you to leave your home, will you:

☐ Go to a friend or family member's home

☐ Go to a community shelter

☐ Need to go to a hospital or care facility

Will you need transportation? ☐ Yes ☐ No

If yes, what type of transportation: ☐ automobile ☐ lift van ☐ ambulance

**IV. Your Health and Circumstances:**

Physician Name:_____

Phone:_____

Please Check all that Apply:

☐ Live-sustaining equipment required ☐ Uninterrupted electrical service is essential

Please list below the equipment that you use:

_____

_____

_____

_____

☐ Ventilator ☐ Supplemental oxygen ☐ Life Sustaining Medication

☐ Home Care Assistance ☐ Cardiac ☐ Blood Pressure ☐ Full time ☐ Daily

☐ Respiratory ☐ Diabetes ☐ Several days/week ☐ Monthly

☐ Other:_____

Vision Impairment ☐ Service Animal ☐ Low Vision Type: ☐ Sight

Hearing Service ☐ Legally Blind ☐ Other:_____

Mobility Impairment ☐ Speech Impairment ☐ Walker ☐ Wheelchair

☐ Scooter ☐ Immobile ☐ Interpreter Required

Language:_____

Hearing Impairment

☐ Hard of Hearing ☐ Mental or Behavioral Condition ☐ Deaf

**V. Describe diagnosed medical conditions, health needs, or needed accommodations:**

_____

_____

_____

_____

Submitted by

(Name):_____

Relationship: ☐ Family ☐ Friend ☐ Caregiver ☐ Neighbor ☐ Legal Guardian

☐ Other or ☐ Organization

Specify:_____

Phone: Work:_____ Home:_____

Cell:_____ Email: _____