BROWNWOOD/BROWN COUNTY HEALTH DEPARTMENT

PUBLIC HEALTH PREPAREDNESS

*** Please complete one form per person. ***

Last, First Name: _____Age: _____

Physical Street Address *(No P. O. Box)*
Street Number and Name: _____

Apt/Suite Number: _____ City: _____ Zip Code: _____

Home Phone: _____Cell Number: _____

Email: _____

Emergency Contacts - Please list two (2)

Name: _____

Relationship to you: _____

Phone Number: _____

Name: _____

Relationship to you: _____

Phone Number: _____

Do you wish to receive: ☐ General Messages ☐ Emergency Messages ☐ Both

Do you have someone that reliably checks on you? ☐ Yes ☐ No

Do you have a service animal or other pets? ☐ Yes ☐ No Explain: _____

Do you have reliable transportation? ☐ Yes ☐ No Preferred Language: _____

What medical conditions do you have?

☐ Vision
☐ Hearing
☐ Respiratory
☐ Alzheimer's
☐ Dialysis
☐ Mental Health
☐ Other: _____
☐ Other: _____

Do you weigh over 350 pounds? ☐ Yes ☐ No

What durable or bulky medical equipment do you require?

☐ Wheelchair
☐ Powerchair
☐ Cane
☐ Walker
☐ Nebulizer
☐ Crutches
☐ Other: _____
☐ Other: _____

Does any of your medical equipment require a power source? ☐ Yes ☐ No

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