



PUBLIC HEALTH PREPAREDNESS

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2025

*** 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

Source of Registration: [] Senior Citizen Center [] Website [] Home Health/Hospice [] Other _____