

SPECIAL NEEDS REGISTRY FORM

DATE SUBMITTED _____

NAME _____
ADDRESS _____
EMAIL _____
DATE OF BIRTH _____
HOME PHONE _____
OTHER PHONE _____

EMERGENCY CONTACT INFORMATION

NAME _____
ADDRESS _____
HOME PHONE _____
OTHER PHONE _____

IMPAIRMENTS

- | | |
|---|--|
| <input type="checkbox"/> DEAF | <input type="checkbox"/> COLOSTOMY |
| <input type="checkbox"/> BLIND | <input type="checkbox"/> ILEOSTOMY |
| <input type="checkbox"/> SPEECH | <input type="checkbox"/> G-TUBE |
| <input type="checkbox"/> MOBILITY | <input type="checkbox"/> CATHETER |
| <input type="checkbox"/> CARDIAC | <input type="checkbox"/> CONTAGIOUS/INFECTION |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> MULTIPLE SCLEROSIS |
| <input type="checkbox"/> COGNITIVE LOSS | <input type="checkbox"/> MUSCULAR DYSTROPHY |
| <input type="checkbox"/> ALZHEIMER'S/DEMENTIA | <input type="checkbox"/> PARKINSON'S |
| <input type="checkbox"/> AUTISM | <input type="checkbox"/> PARALYSIS (FULL OR PARTIAL) |
| <input type="checkbox"/> MOOD DISORDER/MENTAL ILLNESS | <input type="checkbox"/> CEREBRAL PALSY |
| <input type="checkbox"/> DEVELOPMENTALLY DISABLED | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> WEIGHT (OVER 250 LBS) | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> DIABETES | |

DO YOU HAVE ANY OF THE FOLLOWING

- | | |
|---|-------------------|
| <input type="checkbox"/> SERVICE ANIMAL | |
| <input type="checkbox"/> CAT | |
| <input type="checkbox"/> DOG | NO. OF PETS _____ |

OTHER ITEMS

- I HAVE A SERVICE ANIMAL
 I NEED TRANSPORTATION
 I NEED ASSISTANCE WITH BASIC CARE
 I LIVE ALONE

DOES YOUR CARE REQUIRE THE USE OF ANY OF THE FOLLOWING

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> OXYGEN | <input type="checkbox"/> WALKER |
| <input type="checkbox"/> VENTILATOR/RESPIRATOR | <input type="checkbox"/> CANE |
| <input type="checkbox"/> DIALYSIS | <input type="checkbox"/> CRUTCHES |
| <input type="checkbox"/> IV SUPPORT | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> WHEELCHAIR | |