COLUMBIA COUNTY SPECIAL NEEDS REGISTRY
REGISTRATION FORM

(Information will be used to assist residents with special medical needs in the event of an emergency)

Name_____ DOB_____ Phone_____

Cell Phone_____ Street Address_____

Village/City_____ Town _____Zip_____

Mailing Address (if different from above) _____

Email Address _____ TDD/TDY (for hearing impaired) ☐ No ☐ Yes

Person to Contact in an Emergency_____

Relationship to Emergency Contact _____

Home Phone _____Work Phone _____Cell Phone _____

Check applicable medical conditions: Check any of the following you require:

☐	Use Wheelchair	☐	I Require Oxygen and/or have an oxygen machine
☐	Respirator	☐	Walk with walker, cane, or crutches
☐	Legally Blind	☐	Hearing Impaired
☐	I am on a Plura-vac	☐	Bedridden - require a 24-hr caregiver
☐	Speech-impaired	☐	Require frequent suctioning

☐ Other: _____

Is this an ongoing need? ☐ No ☐ Yes Estimated end date of need _____

Do you have pets? ☐ No ☐ Yes Number of pets _____ Type of pet/s_____

Acknowledgement of Receipt of Notice of Privacy Practices and Authorization to Release Information

The Signatory below certifies that the above information is correct and that they have received, or have been offered, a copy of the Registry's Notice of Privacy Practices. They authorize the release of any medical or other information necessary to all participating agencies affiliated with the Special Needs Registry, and those responsible for emergency management and response, in order to maintain an accurate registry, and to adequately respond in an emergency as resources permit. They will also immediately advise the Columbia County Emergency Management Office if the status of the noted special need/s should change.

Furthermore, the Signatory understands that participating in the Special Needs Registry does NOT guarantee special rights or services, and depending on the scope of the emergency, Columbia County may not be able to assist them.

Identity of the Signatory is: (please circle one) Registrant Parent Power of Attorney Court Appointed Guardian

Contact number of Signatory (If different than Registrant) _____

Print Name _____ Date _____

Signature_____

Send completed forms to Columbia County Department of Health, 325 Columbia Street, Hudson, New York 12534