

-EMERGENCY INFORMATION --- CONFIDENTIAL

*****EVACUATING COUNTY RESIDENTS IN NEED*****		**Municipality
R = REQUIRED		** ECRIN ID NUMBER: ___ - ___ ** A / I / D: ___ Completes
R. Date of Initial Completion: ___/___/___		R. Date of Last Update: ___/___/___
R. House: Own ___ Rent ___ MH/R Group Home ___ CYS Foster Care ___		
R. Do you SPEAK English ? Yes ___ No ___ R. Do you READ English ? Yes ___ No ___ If the answer is NO, what is your Native Language ? _____		
<u>Personal Information</u>		
R. Name: _____		R. Phone: _____
R. Address: _____		R. Cell Phone: _____
R. Township / City / Borough: _____		E-mail: _____
R. Zip Code: _____		R. Date of Birth: / /
R. Male: ___ Female: ___		
R. Mobility: Check if the answer is 'yes.' ___ Confined to Bed ___ Confined to Wheelchair ___ Require Medical Support Equipment, Oxygen/Ventilator, or Other: _____ ___ Walk with Walker, Cane or Other: _____ ___ Hearing impairment ___ Sight impairment ___ Other Personal Situation: _____ ___ Without any Personal Means of Transportation ___ Service Animal		
R. I might not be able to evacuate without help due to a: Mental Disability, Mental Retardation, Autism, Alzheimer's or due to not being able to verbally respond. Yes ___ No ___ ♦ These things make me afraid (Loud Noises, Sirens, Being Approached from Behind, etc.): _____ _____ ♦ This is where I would hide if I was fearful (Inside, Outside): _____ _____		
I must take medicine daily which is prescribed by my doctor. Yes ___ No ___		
Primary Care Physician:		Telephone Number:
Name: _____		Address: _____
EMERGENCY CONTACT:		EMERGENCY CONTACT:
Name: _____		Name: _____
Phone: _____		Phone: _____
Cell: _____		Cell: _____
Address: _____		Address: _____
E-mail: _____		E-mail: _____
Relationship: _____		Relationship: _____
Do you have pets in the household needing evacuation? Yes ___ No ___		

