



THE TOWN OF STRATFORD SPECIAL NEEDS REGISTRY INSTRUCTIONS AND INFORMATION

The Town of Stratford has created a voluntary Special Needs Registry to identify Stratford residents who might need extra assistance during a major emergency, such as a mass evacuation, a public health emergency like a pandemic, or an independent emergency like a health crisis or fire in your home. The town's emergency response will be more effective if responders are aware of your special situation prior to their arrival.

You should register and supply information on your individual circumstances if:

- You need special notification about the emergency due to impairment or language barrier.
- You need assistance to leave your home due to a disability or other physical challenges.
- You have no access to transportation.
- You could not stay in your home without assistance for more than a couple of days.
- You rely upon electrical power for specialized equipment in your home.

The Registry:

- Provides emergency planners with your information so that during a disaster, responders can determine where special assistance is required.
- Keeps your information secure. It will only be used for emergency preparedness or response.

While enrollment is no guarantee that you will get help first during a disaster, Stratford's Emergency Operations Center will know of your need for special assistance.

**Please remember, even if you are on the Special Needs Registry,
you should call 911 if you find yourself in a life-threatening situation.**

You may enroll yourself or anyone else for whom you have legal responsibility. Simply complete and sign the attached form. Please report any changes in your information immediately to the Stratford Health Department by completing an updated application form. We will contact you on an annual basis to remind you to update your information.

The Special Needs Registration form can be printed out on the Town's website at www.townofstratford.com/health or picked up and dropped off at any of the following locations:

**Stratford Health Department
South End Community Center
Baldwin Center
Stratford Library**

The completed forms can also be mailed to:

**Stratford Health Department
468 Birdseye Street
Stratford, CT 06615**

If you have questions or need further information, please call Stratford Health Department at 203-385-4090. The application packet is also available in other languages and alternate formats (Braille, Large Font) upon request.

SPECIAL NEEDS VOLUNTARY REGISTRATION FORM

If you, or any member of your household, require extra assistance in the event of a major emergency such as an evacuation, please complete and return this form so that your special needs will be available to emergency response personnel. The Town of Stratford will only use your information for emergency preparedness and response.

SPECIAL ASSISTANCE WOULD BE NEEDED FOR:			<input type="checkbox"/> THIS IS A NEW REGISTRATION
			<input type="checkbox"/> THIS IS UPDATED INFORMATION
FIRST NAME	LAST NAME	DATE OF BIRTH	
HOME ADDRESS		ZIP CODE	
		<input type="checkbox"/> 06614 <input type="checkbox"/> 06615	
HOME PHONE NUMBER	CELL PHONE NUMBER	TTY/TTD #	GENDER
		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
EMAIL ADDRESS		PRIMARY LANGUAGE (Including Sign Language)	

Check only those applicable:

NON-ENGLISH SPEAKING HOME *(Note: This form is available in other languages.)*

- I do NOT understand English at all.
- I understand some English.

TRANSPORTATION DURING AN EVACUATION

- I need standard transportation
- I need special transportation (ambulance, lift, etc.)
- Other *(Please Specify)* _____
- I can get to a public bus-stop
- I can provide my own transportation

DISABILITY or other CHALLENGES

- Blind or sight impaired
- Deaf or hearing impaired
- Speech impaired
- Limited mobility or difficulty walking
- Other *(Please Specify)* _____
- Confined to bed
- Require 24 hour constant care
- Mental health condition (dementia, psychiatric)
- Chronic Condition: _____

DEPENDENCY

- Electricity—I require electricity for essential equipment.
- Insulin
- Oxygen
- Other *(Please Specify)* _____
- Service Animal
- Walker / Cane
- Wheel Chair / Scooter
- Dialysis

OTHER, SPECIAL CIRCUMSTANCES

- I have one or more children under age 18 living with me.
- I have one or more pets living with me.

(OVER →)

IMPORTANT INFORMATION:

EMERGENCY CONTACT (Not in household)	ADDRESS	PHONE NUMBER
CARE GIVER NAME (Optional)	ADDRESS	PHONE NUMBER
PRIMARY PHYSICIAN NAME (Optional)	ADDRESS	PHONE NUMBER
PHARMACY NAME (Optional)	ADDRESS	PHONE NUMBER

AUTHORIZATION

I request registration in the Town of Stratford Special Needs Registry. I certify that I have voluntarily provided the above information and that it is true and correct to the best of my knowledge. I have read the information sheet attached with this registry form and I understand the limitations on services and the level of care available.

I understand that I remain responsible for any costs associated with hospital or other medical care.

I understand that enrollment in the special needs registry is no guarantee that transportation or support services will be provided by the Town of Stratford. I understand that I remain responsible for myself in the event of an emergency and I should call 911 if I find myself in a life-threatening situation even if I am on the Special Needs Registry

I grant permission to medical providers, pharmacies, transportation agencies and others involved in my care to provide care and disclose any information necessary to respond to my health needs during an emergency.

I grant permission for the release of this information to emergency agencies and personnel.

SIGNATURE	DATE
If someone other than the applicant completed this form, please answer the following:	
NAME	RELATIONSHIP
PHONE NUMBER	DATE

Photo on file with Stratford Police Department

SPECIAL NEEDS VOLUNTARY REGISTRATION FORM

YOU MAY SUBMIT THIS FORM EITHER WAY:

DROP OFF AT:

- Stratford Health Department
- Baldwin Center
- South End Community Center
- Stratford Public Library
- Stratford Police Department
- Stratford Fire Department

MAIL TO:

SPECIAL NEEDS REGISTRY
STRATFORD HEALTH DEPARTMENT
468 Birdseye Street
Stratford, CT 06615

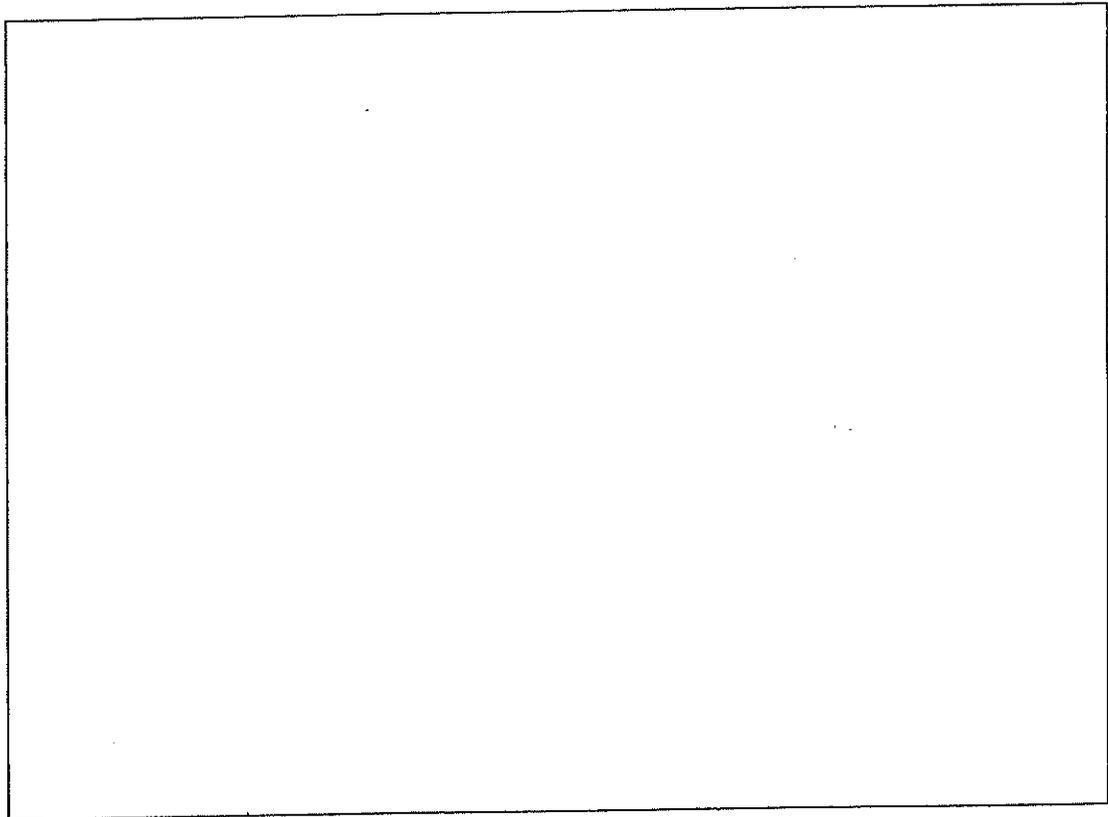
----- For Office Use Only -----

Entered By (Initial):

Date:

Registry #:

PHOTO:
DATE:



SPECIAL NEEDS VOLUNTARY REGISTRATION FORM