

**MANALAPAN TOWNSHIP EVACUATION ASSISTANCE/SPECIAL NEEDS REGISTRATION**

Today's Date: \_\_\_\_\_  Initial Form  Updated Form

Last: \_\_\_\_\_ First: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: Manalapan State: New Jersey Zip: 07726 Telephone: \_\_\_\_\_  Home  Cell

I REQUIRE TRANSPORTATION ASSISTANCE  Yes  No Living Situation  Alone  Relative  Other

Single Family  Apartment/Condo/Townhouse, Complex Name: \_\_\_\_\_

Do you have a pet?  Do you have a crate?  Arrangements for pet completed-Call 732-446-8345 for assistance

**SPECIAL NEEDS (CHECK ALL THAT APPLY) Questions Call Health Dept. – 732-446-8345**

<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Walker/Cane	<input type="checkbox"/> Feeding Tube
Dialysis where _____	<input type="checkbox"/> Memory Impairment	<input type="checkbox"/> Wheelchair user	<input type="checkbox"/> Ventilator
_____	<input type="checkbox"/> Mental Health Impaired	<input type="checkbox"/> Bedridden	<input type="checkbox"/> Medical/Electrical dependent,
<input type="checkbox"/> Diabetes/Insulin Depend	<input type="checkbox"/> Sight Impaired	<input type="checkbox"/> Incontinence	Why? _____
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Service Dog	<input type="checkbox"/> Oxygen (lpm____ )	_____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Speech Impaired	<input type="checkbox"/> Geri Chair	<input type="checkbox"/> Cancer
<input type="checkbox"/> Stroke	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Breathing Treatment	<input type="checkbox"/> None
<input type="checkbox"/> Other _____			

**EMERGENCY CONTACTS**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Prearranged:  Hospital  Nursing Home  Assisted Living Facility (ALF)  Other \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

By signing this form I give my authorization for the medical information contained herein to be released to the local/county health dept, emergency management and receiving facilities for the purpose of evaluating my needs and providing emergency transportation and sheltering.. The information contained here will be kept confidential.

\_\_\_\_\_  
Signature Date

Official Use Only  
Date Form Received \_\_\_\_\_ Date Form Entered \_\_\_\_\_

Comments: \_\_\_\_\_

**Mail completed form to: Manalapan Twp. Office of Emergency Management, 120 Freehold Rd Manalapan, NJ 07726  
Attn: Special Needs/Evacuation Form or Fax to 732-446-1576 or email to SpecialNeedsForm@ManalapanOEM.com  
For more information call the Office of Emergency Management at (732) 446-8329**