Village of Green Island

Voluntary Registry for Vulnerable People

It is requested that this form be completed by Green Island residents who may be vulnerable in the event of an emergency.

_____

Last **First** **Middle Initial**

_____

Address **Apt. #**

_____

Home Phone **Cell Phone** **Email**

Date of Birth: _____/_____/_____ **Gender**: ☐ **Male** ☐ **Female** ☐ **I prefer not to say**

Number of individuals living with you: _____**Residence Type:** ☐ **Private Home** ☐ **Apartment**

Do you have pets: ☐ **YES** ☐ **NO** **Do you have a plan for your pets in an emergency?** ☐ **YES** ☐ **NO**
(Please note the Village of Green Island will not be responsible for your pets in the event of an emergency)

Is English your primary language? ☐ **YES** ☐ **NO**

If No, what is your primary language? _____

Emergency Contact:

_____

Last **First** **Middle Initial**

_____

Address **Apt. #** **City** **State** **Zip**

_____

Home Phone **Cell Phone** **Email**

Relationship to above named person: _____

Please indicate if you are using any of the following:

YES	**NO**	**Are you on home oxygen? Hours per day:** _____ **Litre Flow:** _____
YES	**NO**	**Do you use a Medical Alert System?**
YES	**NO**	**Are you on home dialysis?**
YES	**NO**	**Do you have a suctioning unit?**
YES	**NO**	**Do you have a SIDS monitor?**
YES	**NO**	**Do you have a cardiac monitor?**
YES	**NO**	**Do you have a heart pacemaker?**
YES	**NO**	**Do you have any medications that require refrigeration?**
YES	**NO**	**Do you have any other special needs that require electric, natural gas, or telephone?**

Explain: _____

_____

_____

Please check all that apply:

YES	**NO**	**Are you dependent on any medical equipment that requires electric?**
YES	**NO**	**Do you care for yourself?**
YES	**NO**	**Do you regularly have assistance from a caregiver?**
YES	**NO**	**Are you ambulatory, ☐ with assistance?**
YES	**NO**	**Wheelchair dependent?**
YES	**NO**	**Walker/cane dependent?**
YES	**NO**	**Are you bedridden?**
YES	**NO**	**Are you hearing impaired?**
YES	**NO**	**Are you visually impaired?**
YES	**NO**	**Do you have a mental disability?**
YES	**NO**	**Medicine Allergy, if so what medicine(s):**

_____

_____

YES NO **Other**
Explain: _____

_____

_____

Please list all of the medications you are presently using:

_____

_____

_____

_____

_____

I grant permission to emergency response agencies and others as necessary to provide care and disclose any information necessary to respond to my needs. I understand my participation in this registry is voluntary and all information maintained will be used only for emergency purposes. To the best of my knowledge the information contained herein is true and correct.

Registrant Signature: _____ **Date:** _____

Caregiver: _____ **Date:** _____
(If registrant is unable to sign)

Relationship to Registrant (if any): _____

Please return this form back to:

Village of Green Island
C/O Volunteer Registry for Vulnerable People
20 Clinton Street
Green Island, NY 12183