RILEY COUNTY HEALTH DEPARTMENT

Public Health
Prevent. Promote. Protect.

Medically Vulnerable Population
Voluntary Registry Form

Please complete this form and return OR mail to:
Riley County Health Department, Public Health Emergency Preparedness, 2030 Tecumseh Road Manhattan, KS 66502
For more information, call 785-776-4779 x 7633

Contact Information

Name: _____
(Last) (First) (MI)

Street Address: _____

City: _____ State: _____Zip Code: _____County of Residence: _____

Mailing Address if different than above: _____

Do you live in a mobile home? □Yes □No If yes, please provide the park name: _____

Primary Phone: _____ Alternate Phone: _____

D.O.B: _____(MM/DD/YY) Age: _____ (years)

Sex: □Male □Female Weight: _____ Height: ___(ft.) ___(in)

Primary Language: _____ Secondary Language: _____

Living Situation: □ Alone □ Relative □ Care Giver □ Home Health □ At-home Hospice

□ Other: _____

Your Care Giver <u>MUST</u> accompany you to a shelter. Please provide their information below:

Name of Care Giver: _____

Relationship to Care Giver: _____ Phone: _____

IN CASE OF EMERGENCY CONTACT

(If other than Caregiver)

Name: _____ Relationship: _____

Phone 1 _____ Phone 2 _____

Transportation Needs

Can you get to a shelter: □ Yes □ No

If no, please check the appropriate transportation need:

□ Car □ Wheelchair-equipped Van □ Ambulance □ Other: _____

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Medical Needs

Electricity Dependent: □ Yes □ No

□ Cardiac Device □ Ventilator □ BiPAP □ IV Infusion Pump □ O_2 Concentrator □ Enteric Feeding □ Suction Pump

□ Other: _____

Oxygen Dependent: □ Yes □ No

Oxygen use: □ 24 Hour □ Only Overnight

Oxygen Type: □ Liquid □ Bottle □ Room Air

□ Intermittent □ CPAP

Mode of Administration: □ Nasal Cannula □ Mask

Liters flow: _____ L/minute: _____

Medical Condition(s):

□ Assistance with medication

□ Medication requiring refrigeration:

Type: _____

Type: _____

□ Mental/Behavioral Health

□ Cognitive Impairment (i.e. Alzheimer's, dementia)

Type: _____

Type: _____

□ Assistance with wound care: _____

□ Vision Loss/Impaired

□ Hearing Loss/Impaired

□ Speech impaired

List any assistive devices, such as glasses, hearing aid, etc.

_____

_____

□ Incontinence: please specify

□ Bowel □ Bladder

□ Mobility impaired: please specify

□ Walker □ Cane □ Scooter □ Crutches □ Wheelchair □ Electric Bed

□ Dialysis Dependent: please specify

□ Peritoneal (PD) □ Hemodialysis □ Schedule: _____

□ Diabetes Type 1 □ Diabetes Type 2

□ Other health impairments or medical conditions not previously listed:

_____

_____

□ Known Food or Drug Allergies: _____

List (or attach a list of) Routine Medications, both prescription and over the counter:

_____

_____

□ Other Medical Equipment: _____

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Medical Contact Information

Primary Doctor: _____ Phone: _____

Home Health Provider: _____ Phone: _____

Home Medical Equipment Provider: _____ Phone: _____

Oxygen Company: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Conditions and Authorization to Release Information, Including Protected Health Information

Please read and initial each of the following:

_____ I understand that my participation in this registry is voluntary, and that all information that I provide will only be used for disasters and emergency planning and response purposes

_____ I understand that at any time, I may ask that my name be removed from the Registry by sending a written (analog or digital) request to Riley County Health Department, Public Health Emergency Preparedness

_____ I understand that while registering this information to aid emergency responders, registration does not guarantee emergency services will be rendered during an emergency or disaster

_____ I grant permission to emergency medical providers, transportation providers, and other emergency preparedness and response partners to enter my residence in an emergency, to provide care and to disclose the information I have provided as needed to respond to my emergency needs. This is not intended to limit a responder's ability to enter or respond to an emergency as allowable by law

_____ I grant permission to medical providers, transportation agencies, and others to provide care and disclose information, as need, to response to my emergency needs

_____ I understand that I must have an adult caregiver with me during my stay at a shelter that will provide routine care to me, the same as would be performed in my own home

_____ I understand that I am responsible for making my own emergency preparations, including provision of medications and medical equipment and supplies, and dietary items that may be required if evacuated from my home

_____ I understand that assistance will only be provided during the duration of an evacuation, emergency, or disaster event and that arrangements should be made in advance in the event I am unable to return to my home

_____ I understand that in the event I am unable to return to my home that i will be responsible for any additional transportation or hospital expenses

_____ I understand that I should call 911 if I am in an emergency

I hereby confirm and attest that the information provided in this registration is correct and that should the information that I have provided change, I will promptly update the registry. I have had the full opportunity to read and consider the contents of this Authorization. I understand that, by signing below, I am confirming my authorization that the Riley County Health Department may disclose to the organizations named in this form the information described in this form.

Signature of Applicant: _____

(Signature) *(Date)*

Print Name: _____

If person filling out this form is not the Medically Vulnerable individual, please answer the following:

Name: _____ Relationship: _____

Phone 1 _____ Phone 2 _____