



City of Williamsburg Special Needs Registry & Heads Up Program

Please fill out this form completely and to the best of your knowledge and return to the following address:

Williamsburg Human Services Phone: (757) 220-6161
401 Lafayette Street
Williamsburg, VA 23185

Required fields are indicated with an *.

GENERAL INFORMATION

*First name: _____

Middle name: _____

*Last name: _____

*Date of birth: _____

*Sex: _____

*Street Address: _____

*City/State/Zip: _____

How many occupants at this address: _____

Email address: _____

How did you hear about the registry/program? _____

*Primary phone number: _____

Phone type TTY SMS Relay Voice

*Secondary phone number: _____

Phone type TTY SMS Relay Voice

Preferred contact method: (circle one) Regular Mail / Email / Primary Phone

Preferred contact time: _____

What is your residence type: House Apartment Other _____

Is there an elevator for use at residence: Yes No

PERSONAL INFORMATION

Do you have a service animal: Yes No Animal weight _____ lbs

Do you have other pets: Yes No

Do you have a care giver or attendant: Yes No

Who is your home health agency: _____

Do you plan to go to shelter if told to evacuate: Yes No

Do you have a generator: Yes No

Do you have an emergency plan: Yes No

Physical Considerations: Bladder Cognitive Disorder
 Mental Condition Seizures
 Bowel Cardiac Condition
 Pulmonary Condition Weigh over 300 pounds

Do you have other physical considerations: _____

Do you use any of the following: Apnea Monitor Special Diet
 Nebulizer Wound Dressing
 Catheter Tracheotomy
 Oxygen IV Therapy
 CPAP Ventilator
 Electricity-intermittent Colostomy
 Electric-continuous Dialysis
 G or J tube Pacemaker or Related
 Hospice care Prescription meds
 Insulin (non-refrig) Suctioning
 Insulin (refrig)

Do you use other medical or therapeutic items: _____

Allergies: _____

Mobility: Ambulatory Power chair or scooter
 Ambulatory with help Walker/cane/crutches
 Manual wheelchair White cane

Do you have other mobility considerations: _____

Do you require assistance with: Bathing Feeding
 Getting dressed Guidance (visual or other)
 Communication Use of Toilet

Is this condition permanent: Yes No

TRANSPORTATION INFORMATION

Do you have access to private transportation: Yes No
Can you ride a regular bus with no lift: Yes No
Do you require an ambulance for transportation: Yes No

Do you use any of the following: HRT Bus/trolley WAT
 Logisticare Taxi
 Handi-ride

Do you have other restrictions/comments: _____

EMERGENCY CONTACT

Primary physician: _____

Physician phone: _____

*Primary emergency contact: Name: _____

*Phone: _____

Phone type: TTY SMS Relay Voice

Alternative phone: _____

Phone type: TTY SMS Relay Voice

Address: _____

City/State/Zip: _____

Second emergency contact: Name: _____

Phone: _____

Phone type: TTY SMS Relay Voice

Alternative phone: _____

Phone type: TTY SMS Relay Voice

Address: _____

City/State/Zip: _____

SUMMARY

Summary of needs or concerns: _____

Person filling out form: _____

Relationship of person filling out form: _____

Date form completed: _____

Information submitted on this form will be used by the Heads Up program and the Medical Needs Registry. The Heads Up program is designed to assist emergency responders in rendering emergency services to Williamsburg residents. The Medical Needs Registry is an emergency preparedness tool that will be used by local emergency managers to communicate with people who have medical needs for emergency preparedness planning purposes. Information is entered into a secure database and will be kept confidential. It is the responsibility of the citizen to report any changes to ensure accurate information. Please contact the Williamsburg Human Services at 757-220-6161 with any further questions or concerns.



FOR OFFICE USE ONLY

Person collecting information: _____

Date entered: _____ Entered by: _____

Date updated: _____ Updated by: _____

Date purged: _____ Reason : _____