MEDICAL SPECIAL NEEDS

EMERGENCY RESPONSE CARD

Johnson County
Iowa

If you, or other members of your household, would require special assistance in the event of an emergency, please complete and return this form by answering the questions on the back side so arrangements can be made to assist you with evacuation should that become necessary. Indicate on the back whether you need special notification or assistance with transportation.

This information will be kept confidential, as required by law, and will be used by local emergency service agencies in your area during times of emergencies.

Emergency Alert System

The Emergency Alert System (EAS) is a group of radio and television stations that broadcast official information during an emergency. If the emergency sirens sound, tune to KCJJ 1630 AM or WMT 600 AM.

Hearing Impaired

The hearing-impaired can receive emergency information on the Telephone Device for the Deaf (TDD).

The Elderly and Disabled

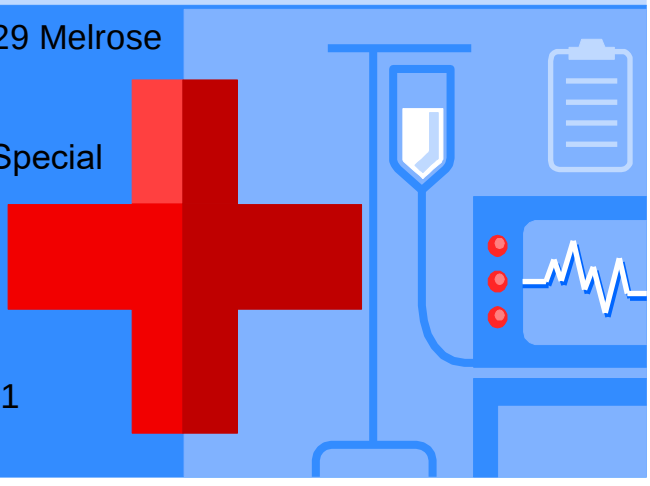
The elderly and disabled can ask for assistance in an evacuation by calling the Johnson County Emergency Management Agency at **(319) 356-6700 or (319) 356-6761**

In an emergency dial 911.

To register mail this form to Johnson County EMA, 4529 Melrose Avenue, Iowa City, IA. 52246 OR register online at **www.johnson-county.com** and go to the Emergency Management link under departments then select the “Special Needs Registry” tab.

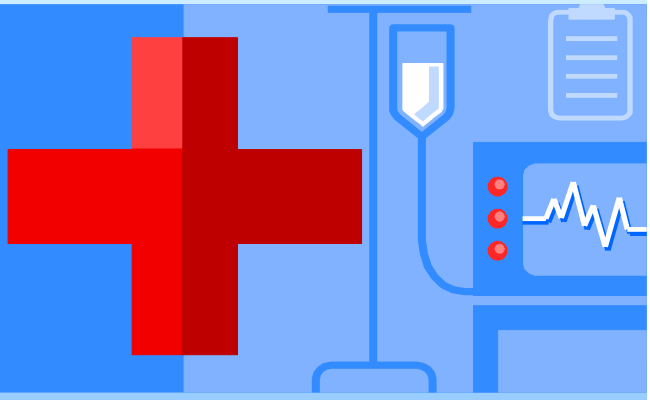
To sign up for emergency alerts go to:
http://entry.inspironlogistics.com/johnson_ia/wens.cfm

Or contact Emergency Management Office at 356-6761 for more information on preparing for an emergency.



Return this form to **Johnson County EMA, 4529 Melrose Avenue, Iowa City, IA. 52246**

SPECIAL NEEDS
Personal Information



Special assistance would be needed for:

NAME(S)_____

ADDRESS_____APT._____

CITY_____STATE/ZIP_____

TELEPHONE #_____PLEASE CHECK IF NO PHONE #_____

EMAIL_____

COMPANION ANIMALS & TYPE_____

_____

Please check what applies to your situation.

_____Full-time resident

_____Part-time resident (circle which months at this address):

JAN FEB MAR APR MAY JUNE JULY AUG SEPT OCT NOV DEC

_____Critical Medications:_____

_____Deaf or hearing impaired _____TDD Telephone number _____Confined to wheelchair

_____Could transfer to regular seats in a bus or van with assistance _____Confined to bed

_____Use electric powered medical devices. If checked, list:_____

_____

____Blind or Sight impaired _____Memory or Mental Health concerns ____ Hearing impaired

____Oxygen _____CPAP or BIPAP ____Feeding Tube _____ Home Ventilator _____

Special emergency assistance required, check only those applicable:

____Specialized Notification of the event ___Transportation Assistance if evacuation is required

____Specialized Medical Needs Sheltering if evacuation required

Alternate emergency contact person:

_____

NAME/RELATIONSHIP TO PERSON NEEDING ASSISTANCE **DAY/Cell TELEPHONE** **NIGHT TELEPHONE**