



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 1560 AM or WMT 600 AM.

Hearing Impaired

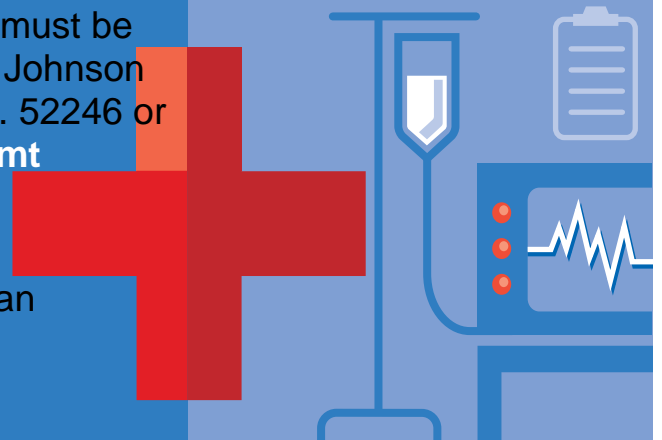
The hearing-impaired can receive emergency information on the Telephone Device for the Deaf (TDD).

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) 356-6761** or **(319) 356-6020**.
In an emergency dial 911.

In order to remain on the registry, this information must be submitted every year. To register mail this form to Johnson County EMA, 4529 Melrose Avenue, Iowa City, IA. 52246 or go to www.johnson-county.com/emergencymgmt

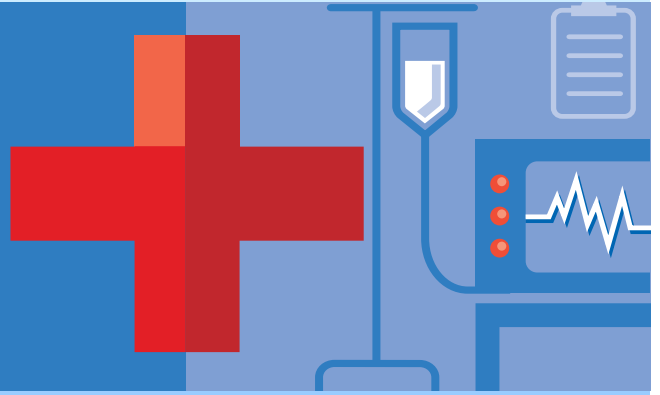
You may also contact your local Emergency Management Office at 356-6761 for more information on how you may prepare for an emergency.



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