

If You Need Special Help in an Emergency

Please fill out this card and place it in the mail immediately. Please print your name.

Age: _____ Sex: M F

Last _____ First _____ MI _____

Address _____ City _____ Zip _____ Phone _____

Your Doctor _____ Phone _____

Emergency contact _____ Relationship _____ Phone _____

Your Special Condition: Eyesight Hearing Speech Emotional Respiratory Walking

Other _____

Special Assistance You Need: Wheelchair Pick-up Oxygen Dialysis Stretcher

Other _____

Address of Pick-up Point: _____

What Agencies Help You: _____

For Emergency Management Use Only

Comments: _____ Confirmed Date: _____ Zone Pick-up Confirmed By: _____