CUMBERLAND COUNTY
SPECIAL NEEDS REGISTRY

Registrant First Name		Registrant Last Name	
Registrant Address:			
Registrant Gender		Registrant Height	
Registrant Weight			
Physical Description of Registrant.			
Registrant Date of Birth		Registrant Phone Number	
Describe any of the registrant's life threatening medical concerns			
If the registrant uses an Epi-pen, please describe the location where it is stored.			
Are there any triggers which affect the registrant?			
Are there any calming methods used for the registrant?			
Does the registrant frequent/gravitate to any locations in particular?			

Does the registrant wear corrective lenses?		☐YES	☐NO
Does the registrant own or frequently operate a motor vehicle? ☐ YES ☐NO			
Please add any additional information you may think will be helpful for first responders to know regarding the registrant.			
Primary Contact First Name		Primary Contact Last Name	
Primary Contact Address:			
Primary Contact Email		Primary Contact Phone	
Relationship to registrant?			

SPECIAL NEEDS
(Check All that Apply)

☐Alzheimer/Dementia	☐Hoarding Disorder	☐Obese
☐Autism	☐I/DD- Intellectual/Development Disability	☐Oxygen Dependent
☐Diabetes/Hyperglycemic	☐Life Alert	☐Project Life Saver
☐Dialysis	☐Mental Health Disorder	☐PTSD (Post Traumatic Stress Disorder)
☐Epilepsy	Mobility Impairment:	☐Service Animal
☐Electricity Dependent	☐Crutches	☐Sight Impairment/Blind
☐Hearing Impairment/Deaf	☐Wheelchair	☐Speech Impairment
	☐Other	☐Other

COMMUNICATION METHODS:
(Check All that Apply)

☐Verbal	☐Sign Language	☐Augmentative/Speech Assistance Device
☐Non-Verbal	☐Written	