

WILTON EMERGENCY CONTACT REGISTRATION FORM

Participant:

Last Name _____ *First Name* _____

Address _____

Phone _____ *DOB* _____ *Email address* _____

Doctor _____ *Preferred Hospital* _____

Emergency Contact 1:

Last Name _____ *First Name* _____

Address _____

Home Phone _____ *Work Phone* _____ *Email address* _____

Cell Phone _____ *Relation* _____

Emergency Contact 2:

Last Name _____ *First Name* _____

Address _____

Home Phone _____ *Work Phone* _____ *Email address* _____

Cell Phone _____ *Relation* _____

Special Needs:

Do You Live Alone ____ *Are Family/Friends Available For Emergency Assistance* ____

Do You Drive ____ *Do You Have A Car* ____

How Long Can You Be Self Sufficient Without Help _____

Do you have a plan if you are unable to stay in your home? _____

Do You Have Any Special Needs In Communicating With Others _____

Is English Clearly Understood ____ *Hearing Impaired* ____

PLEASE COMPLETE OTHER SIDE →→→

Special Needs Continued:

Needed Medications _____

Insulin Dependent _____

Oxygen Dependent _____ **Do You Have A Portable Oxygen Tank** _____

Can You Operate Your Oxygen Tank Without Assistance _____

Wheelchair Bound _____

Bed Bound _____

Walker _____

Cane _____

Deaf _____

Visually Impaired _____

Blind _____

Dementia _____

Alzheimer's _____

Other _____

Form Completed By _____ **Date** _____

Sent in By _____

Please return the completed form to:

Wilton Department of Social Services
180 School Road
Wilton, CT 06897