Town of Sharon Disaster/Emergency Resident Registration Form

Please note that your participation in the Disaster/Emergency Resident Registration Program is completely voluntary. The information on this form will remain confidential and is kept on file at the Fire Department for your health and wellbeing during an emergency situation. Please contact Susan Edinger or Kathie Medeiros at 781- 784-8000 or sharoncoa@townofsharon.org with any updates to this form. Please keep a copy of this form for your records.

PLEASE PRINT CLEARLY

Name:_____ Date of birth: _____

Address:_____ Email: _____

Home Telephone: _____ Cell: _____

Others in home:_____

English speaking: Yes__ No__

Is there an English speaking person in your home? Yes__ No__

Emergency Contacts:

1. Name/Relationship:_____ Address: _____

Phone: Home:_____ Cell:_____ Work:_____

2. Name/Relationship:_____ Address: _____

Phone: Home:_____ Cell:_____ Work:_____

If family not nearby, do you have a friend/neighbor who can transport you?

Name _____ Phone(s): _____

Home Care Agency other help at home:

Name of agency:_____ Phone:_____

Assistance Needed:

Limited hearing: Yes ___ No ___ Limited sight: Yes ___ No ___

Confined to bed: Yes ___ No ___

Use wheelchair: Yes ___ No ___ If yes, can you transfer out of wheelchair? Yes ___ No ___

Use walker: Yes ___ No ___ Need assistance with stairs/walking: Yes ___ No ___

Need electricity for:_____ Do you have a generator? Yes __ No ___

Do you have a Lifeline or other emergency response system? Yes ___ No ___

Lockbox? Yes ___ No ___

continued on other side

Assistance Needed (continued):
Any other problem/assistance needed: _____

_____

_____

Explain any other special needs/circumstances: (i.e., are you diabetic, on dialysis, use oxygen, etc.? Are you a caregiver; do you need a caregiver? Do you have a service animal?)

Please give details; be specific (attach page if needed)_____

_____

_____

Primary Care Physician: _____

Telephone: _____

Pets: include type (dog, cat, etc.), names of each:_____

_____

Name of person who will care for your pets, if any: _____

Phone number(s): _____

Name (print):_____ Date:_____

Signature:_____

RETURN TO:
Sharon Adult Center / Council on Aging
219 Massapoag Avenue
Sharon, MA 02067

Please notify the Adult Center / Council on Aging of any changes to this form.