STRATFORD ALERTS!

Town of Stratford Registry for Residents with Medical and Special Needs
Instructions and Application

What is *STRATFORD ALERTS!*?

A registry for Stratford residents who have a medical or special need that requires preparation before, during and/or after an emergency due to certain conditions, including:

- Use of life support systems such as oxygen, a respirator/ventilator, dialysis, a pacemaker, or are insulin dependent
- Limited mobility or difficulty walking
- Blind or visually impaired, deaf or hearing impaired, or other sensory condition
- Speech, developmental, or mental health disabilities
- Use of service animals

Why Should I Sign Up?

By registering for *STRATFORD ALERTS!*, you will be put in a notification system that will allow Town officials to alert you before, during, and/or after an emergency. Information is also shared with first responders so that they will know of your need prior to arriving on scene should you ever require emergency assistance. *Note: enrolling does not guarantee that you will get help first during an emergency or that you will be provided a certain level of care or service*.

How Do I Join?

To enroll yourself or anyone else for whom you have a legal responsibility simply complete, sign, and submit the attached form. The Stratford Health Department will send an annual reminder to request updated information.

All information collected through this registry is protected and is only used during an emergency by the Town of Stratford Emergency Personnel.

The *STRATFORD ALERTS!* application can be found online at www.stratfordct.gov/health

You can email your completed application to health@townofstratford.com or mail or drop off at any of the following locations:

Stratford Health Department: 468 Birdseye Street, Stratford, CT 06615

Baldwin Senior Center: 1000 W Broad Street, Stratford, CT 06615

If you have questions or need further information, please call 203-385-4090. The application packet is available in other languages and alternate formats.

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General Information: *Fields marked with an asterisk (*) are mandatory. Please print clearly.*

First Name*: ______________________ Last Name*: ___________________ Suffix (Jr., Sr., III):______

Home Address*: ____ Apt./Unit #: ________

City, State, Zip Code*: ____

Are you a temporary resident of Stratford? *(Moving out in less than 12 months)* ☐ Yes ☐ No

Home Phone Number: ___________________________ Cell Phone Number: ________________________

Email Address: ____

Date of birth (mm/dd/yyyy): _____________________ Gender: ☐ Male ☐ Female

Primary Language (including sign language): ____

Caregiver Name (*optional*): ______________________________ Phone Number: _____________________

Primary Physician Name (*optional*): _______________________ Phone Number: _____________________

Pharmacist Name (*optional*): ______________________________ Phone Number: _____________________

Emergency Contact Information:

First Name: _______________________ Last Name: ___________________ Suffix (Jr., Sr., III):______

Relationship: ____

Primary Phone Number: ____

Email address: ____

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Please check only those applicable:

☐ Deaf or hearing impaired
☐ Blind or sight impaired
☐ Speech impaired
☐ Chronic condition: _______________
☐ Developmental disability (e.g. autism)
☐ Require a ventilator/respirator
☐ Require portable oxygen equipment
☐ Require a wheelchair/scooter/walker
☐ Confined to a bed
☐ Limited mobility or difficulty walking
☐ Require 24 hour care
☐ Alzheimer's/Dementia/Psychiatric Disability
☐ Unable to communicate verbally
☐ Require electricity for life sustaining equipment
☐ Insulin dependent
☐ Require a pacemaker
☐ Dialysis
☐ Other (please specify):_____________________

Do you have access to transportation? ☐ Yes ☐ No
**Access to transportation must be fulltime/dedicated, not public or para transit*

Do you have a service animal? ☐ Yes ☐ No

Do you have one or more children under the age of 18 living with you? ☐ Yes ☐ No

Do you one or more pets living with you? ☐ Yes ☐ No

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Conditions and Authorization to Release Information, Including Protected Health Information
PLEASE READ AND INITIAL THE FOLLOWING:

I understand that my participation in the Town of Stratford *STRATFORD ALERTS* is voluntary and that all information provided will only be used for emergency planning and response purposes. _____

I understand that, at any time, I can request that my name and information be removed from the *STRATFORD ALERTS!* by submitting a request in writing to the Stratford Health Department. _____

I understand information will only be used to assist first responders in understanding the condition with which they will be met upon responding, but does not guarantee a specific level of care/service be provided. _____

I understand that my enrollment in the *STRATFORD ALERTS!* does not guarantee that transportation or support services will be provided by the Town of Stratford during an emergency or disaster. _____

I understand that I remain responsible for myself in the event of an emergency and should call 911 if I find myself in a life-threatening situation. _____

I understand that I remain responsible for any costs associated with hospital or other medical care. _____

I understand that I am responsible for making my own emergency preparations, including the provision of medications, medical equipment and supplies, and dietary items that may be required if I am evacuated from my home. _____

I understand that assistance may only be provided for pre-event communication/planning and during the duration of an evacuation, emergency, or disaster event. _____

I grant permission for the release of this information to State and local emergency medical providers, transportation agencies, and other emergency preparedness and response partners working with the Town of Stratford during times of disaster or emergency. _____

I hereby confirm and attest that the information voluntarily provided in this registration is true and correct to the best of my knowledge. Should the information that I have provided need to change or should I wish to be removed, I will provide a request in writing. I have had the full opportunity to read and consider the contents of this Authorization. I understand that, by signing below, I am confirming my authorization that the Stratford Health Department may disclose the information described above to the organizations named within this form. I understand the limitations on service and the level of care available. _____

Signature of Applicant: ____ Date: _____________

Print Name: ____

If someone other than the applicant completed this form, please answer the following:

Name: ____ Relationship: _____________________

Phone Number:____________________________ Email: _______________________________________