Special Medical or Special Needs Form

Please fill out this form and mail to:
Lebanon Emergency Management Director
Lebanon Town Hall
579 Exeter Road, Lebanon, CT 06249

_____ **Age:** _____ **Sex: M F**
Last First MI

_____
Address Apt. # City/State Zip Telephone

Your Special Condition:
(Check all that apply)

Eyesight	_____
Hearing	_____
Speech	_____
Walking	_____
Respiratory	_____
Other	_____

_____

Special Assistance You May Need:
(Check all that apply)

Wheelchair Pick Up	_____
Oxygen	_____
Dialysis	_____
Stretcher	_____
Insulin	_____
Other	_____

_____

What Agencies Help You?
(Visiting Nurse, Home Health Aide, Van Transportation, Meals on Wheels, Hospice, etc.?)

Agency Name	**Service Provided**	**Contact Name/Telephone**

Physician Name: _____ **Telephone:** _____

Do you have pets? Cat ___ **Dog** ___ **Service Animal:** ___ **Other:** _____

Emergency Contact: Name: _____ **Telephone: ( ) _____**

Relationship to Client: _____

Person Completing Form: _____ **Telephone: ( ) _____**

_____ _____
Signature of Person Completing Form **Date**