Living Safely
with disabilities and special health needs

Emergency Medical Services Safety Information

for Residents with Disabilities and Special Health Needs

Information provided and recorded is confidential and for the purpose of safety. Information provided by or for the resident is voluntary. The person has the option to answer or decline to answer any or all questions.

Municipality: _____

◯ Initial ◯ Updated Date: _____ Completed by: _____

Name of Resident: _____

Resident's preferred name: _____ Resident's preferred pronouns: _____

Resident's email address: _____ Phone number: _____ Other: _____

Method of interaction: ◯ Fully independent ◯ Supported by parent, caregiver, guardian, etc. ◯ Needed support _____

Primary language : _____ Other language? _____ Needs alternative/augmented communication: ◯ Yes ◯ No _____

Method of communication: ◯ verbal ◯ alternative/augmented communication device ◯ ASL ◯ other _____

Mobility : _____ Mobility needs/supports: ◯ cane ◯ walker ◯ wheelchair ◯ other _____

Residence: ◯ Apartment ◯ House ◯ Other Address _____

Other people in the residence, including others with disabilities or special health needs? ◯ Yes ◯ No _____

Age of resident: _____ Resident's description of disability(ies)/special health need(s): _____

Does resident have any medical equipment? ◯ Yes ◯ No _____

Sensory challenges (sirens, equipment, touch, etc): _____

Who should be notified of a medical emergency? _____

Does resident have a caregiver or aid to assist in care/medical care? ◯ Yes ◯ No _____

What is the resident's comfort or concerns level interacting with emergency responders and being transported in an emergency vehicle? _____

_____

Does the resident wear or carry any medical identification? ◯ Yes ◯ No _____

Does the resident need assistance acquiring medical identification? ◯ Yes ◯ No _____

Critical medical information: _____

_____

_____

_____

_____

Is there any additional information that the resident would like to share about emergency rescue or response? (suggestions in case there is a medical emergency)

_____

_____

_____

_____

_____

_____

Notes and recommendations: _____

_____

_____

_____

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NJ DIVISION OF DISABILITY SERVICES

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