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 well being during an emergency situation.

Please contact Cristobal Sanchez or Beth Caruso at 781-784-8000 or sharoncoa@townofsharon.org with any updates to this form.

PLEASE PRINT CLEARLY

Name:_____ Date of Birth: _____

Address:_____

Phone: _____ Cell: _____ Email:_____

Others in home: _____

English speaking: ❑ YES ❑ NO If no, is there an English speaking person in your home? ❑ YES ❑ NO

EMERGENCY CONTACTS:

1. Name/Relationship: _____

   Address:_____

   Phone: _____Cell:_____Work:_____

2. Name/Relationship: _____

   Address:_____

   Phone: _____Cell:_____Work:_____

If family is not nearby, do you have a friend/neighbor closeby with your house key & car who can transport you?

Name:_____Phone(s):_____

Home Care Agency/other help at home: Name of agency: _____

Phone: _____ How often does someone come in? ❑ Daily ❑ Weekly ❑ Other

Please Describe: _____

If you are an active member of a house of worship, they may be able to assist you in an emeregency. You may provide information about your house of worship if you wish to.

Name of Organization/Contact: _____

Phone: _____

ASSISTANCE NEEDED

❑ Limited Hearing ❑ Limited Sight ❑ Confined to Bed ❑ Walker

❑ Need assistance with stairs/walking ❑ Use Wheelchair Can you transfer out of wheelchair? ❑ YES ❑ NO

Seizure Disorder: _____

Memory, Dementia or related problem: _____

Depression/other mood related problem: _____

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

Any other problem/assistance needed: _____

_____

Explain any other special needs/circumstances: (i.e, are you diabetic, on dialysis, hospice care, oxygen or other life support devices, etc.? Are you a caregiver; do you need a caregiver? Do you have a service animal, TDD communicator, etc?) **Please give details; be specific (attach page if needed)**

_____

_____

Physician: _____ Phone: _____

Hospital: _____ Phone: _____

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

_____

Other Animals:(horse(s), cow(s), etc. _____

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

Name: _____ Phone: _____

AUTHORIZATION:

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.
Please keep a copy of this form for your records.

ERR 4.9.2024