HEADS UP! PROGRAM APPLICATION

Isle of Wight County - Emergency Communications Center

17110 Monument Circle, PO Box 75, Isle of Wight, VA. 23397

Phone: 757-357-2151 Fax: 757-357-0706

Purpose: To provide information to public safety agencies related to an individual's disabilities, medical issues, mobility, or other conditions of which emergency responders should be aware. This does not take the place of an individual's responsibility to plan and prepare for transportation and/or sheltering in the event of an emergency. All information provided will remain completely confidential and will be used only by authorized personnel to assist in an emergency. The original of this form shall be kept in a secure location, and distribution or copying of this form is strictly prohibited.

Instructions: Complete all parts of this form. Please PRINT the information. A separate form must be prepared for each individual with special needs residing at a single location. When complete, sign and return the form to the address or fax number above. Form can be completed online at www.IWUS/HeadsUp

PERSONAL INFORMATION

Last Name:	First Name:	M.I.:	DOB: (mm/dd/yyyy)	Sex: ☐ M ☐ F
Street Address:		Town / County	Zip:	Mobile Home: ☐ Y ☐ N
Name of Housing Complex, MH Park, Apartment Building, etc.:		Building, Apt, Room #:	Floor #:	Elevator: ☐ Y ☐ N
Primary Phone Number:	Secondary Phone Number / TDD	Living Situation: ☐ Lives Alone ☐ With Spouse ☐ With Children ☐ With Parent ☐ With Other		Ramp: ☐ Y ☐ N

EMERGENCY CONTACTS (Must provide at least one phone number)

Name:	City, State:	Primary Phone Number:	Secondary Phone Number:
(1)			
(2)			

SPECIAL NEEDS DETAILS (Check and complete each that applies to the applicants condition)

Mobility: ☐ Walks by self ☐ Walks with assistance (cane, walker, etc.) ☐ Wheelchair ☐ Bebridden
If bedridden, can the applicant be moved by wheelchair? ☐ Y ☐ N

Communication: ☐ Speech Impaired ☐ TDD ☐ ASL ☐ Other language spoken (describe) _____
☐ Other communication difficulties (describe) _____

Life-Sustaining Medical Equipment: ☐ Oxygen in use ☐ IV Therapy ☐ Nebulizer ☐ Respirator (Ventilator) ☐ Suction Machine
☐ Other (describe) _____

Other Needs: ☐ Hearing Impaired ☐ Memory Impaired ☐ Catheter or Drain ☐ Weight >300lbs.
☐ Sight Impaired ☐ Anxiety / Depression ☐ Service Animal ☐ Allergies (describe) _____
☐ Mental Health Impaired (describe) _____
☐ Autism Spectrum Disorder (describe) _____

EMERGENCY ALERT / MEDICAL ALERT / LIFE CALL DEVICE

Device Type:	Alarm Company:	Phone Number:

HOME HEALTH CARE AGENCY

Agency Name:	Point of Contact:	Phone Number:

AUTHORIZATION

I understand this information will be utilized to plan appropriate care and treatment during an emergency. I understand that only those persons who have a need to know this information will have access to it. I understand that it is my responsibility to keep the provided information current. I understand that I am responsible for all expenses incurred in association with medical evaluation and special sheltering in a hospital or nursing facility. I accept the conditions as specified and grant permission for Isle of Wight County Emergency Communications Center to record this information in the Computer Aided Dispatch system for reference and to release this information to emergency response agencies via two-way radio in the event of an emergency.

Signature: ☐ Applicant ☐ Guardian	Date: (mm/dd/yyyy)
Guardian Name: (printed)	Phone Number:

***** ECC USE ONLY ***** **Received By:** **Date Processed:** **Processed By:**