Are You Ok? – R.U.O.K?
A Special Needs Registry Program

Clifton Park Citizen Corps Council
Clifton Park Town Hall
One Town Hall Plaza
Clifton Park, NY 12065
Phone: (518) 371-6651
Fax: (518) 371-1136

PLEASE PRINT
This form must be completed in full or it will be returned to you.

Last                First                Middle

Name of Complex or Subdivision

Street              Apt. #              Town                 State      Zip

Home Phone          Cell Phone          E-mail

Mailing address (if different from above)

Sex: Male          Female
Weight ______ lbs  Height _____ ft _____ in  Date of Birth ___/___/___

Full-time Resident?  Yes          No  Dates residing in Clifton Park:

Location of Bedroom (including floor number, front or back and left or right side of house):

Person filling out form if different from above:

Name: ________________________ Address: ______________________________  Phone: ______________

Relationship to Registrant: __________________________________________

Evacuation Info: Do you require evacuation assistance?  Yes          No  If yes:
Ambulatory          Ambulatory with assistance          Wheelchair dependent          Confined to bed

Medications: Do you have a medication list?  Yes          No
Do you have a File/Vial of Life?  Yes          No

Special Equipment: Is electricity required?  Yes          No
Oxygen          Dialysis          Intravenous          Wheelchair          Defibrillator          Walker/cane/crutches
Suction          Diabetic monitoring equipment          Other ______________________________
Disability/Condition (please check all that apply):

- Blind
- Non-Verbal
- Hearing Impaired
- Have a hearing/seeing eye dog to accompany you?
- Require translator (language)
- Breathing Problems
- COPD
- Asthma
- Emphysema
- Require oxygen: occasional or continuous
- Mental Disability
- Dementia
- Psychiatric Diagnosis ________________________________
- Cardiac
- Dialysis
- Seizures
- Diabetic
- Stroke
- Other ________________________________

Emergency Contacts:

Family (not residing with you)  Neighbor
Name: _______________________
Phone: _______________________
Cell Phone: ___________________
Address: ______________________
_____________________________

Caregiver  Primary Physician (optional)
Name: _______________________
Phone: _______________________
Cell Phone: ___________________
Address: ______________________
_____________________________

I certify that the information provided is correct to the best of my knowledge and that my participation in this program is entirely voluntary. As a participant in this program I understand that the Town of Clifton Park does not guarantee, nor is under any obligation to provide, any services as a result of my submission of this form(s). I understand that assistance is provided only during emergencies, and that I should make alternative housing arrangements, in advance, in case I cannot return to home.

I hereby grant permission for the release of this information to my local emergency services in order to assist them in responding to my needs and requests during an emergency situation. I understand that I, not the Town of Clifton Park, will be responsible for costs and charges I incur, associated with an emergency or disaster response.

Signature of Applicant: ____________________________ Date: __________

Signature of Legal Guardian: ____________________________ Date: __________

Do not write below this line

Fire District ________ Amb District ________ Evacuation Level ________ Reviewed by __________