

IF YOU NEED SPECIAL HELP IN AN EMERGENCY

Please fill out this form and mail to: Colchester Emergency Management Director
127 Norwich Avenue, Colchester, CT 06415. Please mark "Confidential" on lower left of envelope.



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

Address _____ City _____ Zip _____ Phone _____

Your Special Condition: (Circle all that apply) Eyesight Hearing Speech Walking Respiratory Emotional
Other: _____

Special Assistance You Need: (Circle all that apply) Wheelchair pick-up Oxygen Dialysis Stretcher
Other: _____

Address of Pick-up Point: _____

What Agencies Help You? _____ Your Doctor: _____ Phone: _____

Name of Person Completing Form: _____ Relation to Special Needs Client: _____

Phone Number: _____ Alternate Number: _____ Date Form Completed: _____