

# Are You Ok? – R.U.OK?

A Special Needs Registry & Call Program

Clifton Park Town Hall  
One Town Hall Plaza  
Clifton Park, NY 12065



Phone: (518) 371-6651 ----- Fax: (518) 371-1136 ----- jspiegel@cliftonpark.org

Use Tab Key to move to next field and type in, or send to printer and fill out. If filled out by hand, 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 **Where:** \_\_\_\_\_

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    continuous

Mental Disability    Dementia    Psychiatric Diagnosis \_\_\_\_\_

Cardiac    Dialysis    Seizures    Diabetic    Stroke    Other \_\_\_\_\_

**Emergency Contacts:**

Family (not residing with you)

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Neighbor

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Caregiver or Family at home

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Primary Physician (optional)

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

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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

You may save with an electronic signature or print it out and sign with a pen and scan it. Please email completed form to [jspiegel@cliftonpark.org](mailto:jspiegel@cliftonpark.org) disaster response.

Signature of Applicant: \_\_\_\_\_

OR Signature of Legal Guardian: \_\_\_\_\_

**Do not write below this line**

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Fire District \_\_\_\_\_ Amb District \_\_\_\_\_ Evacuation Level \_\_\_\_\_ Reviewed by \_\_\_\_\_