

## Emergency Needs Community Survey

I give permission to the Rocky Hill Board of Health (RHBOH) to use the information that I am providing on this survey to assist in updating and revising the Borough's Emergency Management Plan. I understand that the information that I provide will be treated confidentially and may be shared with selected personnel from the Rocky Hill First Aid Squad and the Rocky Hill Hook and Ladder Company to better prepare these volunteer first responder services to meet my/my family's needs in the event of an emergency.

I (check one) **do** \_\_\_\_\_ **do not** \_\_\_\_\_ give the RHBOH permission to share the information that I provide with the **Captain, 1<sup>st</sup> and 2<sup>nd</sup> Lieutenants of the Rocky Hill First Aid Squad.**

I (check one) **do** \_\_\_\_\_ **do not** \_\_\_\_\_ give the RHBOH permission to share the information that I provide with the **Fire Chief, Assistant Chief, Captain and Lieutenant of the Rocky Hill Hook and Ladder Company.**

Name of person completing the survey (please print): \_\_\_\_\_

Signature of person completing the survey: \_\_\_\_\_ Date: \_\_\_\_\_

1. Rocky Hill Address: \_\_\_\_\_
2. Number of people who live at the address in listed in (1) above. \_\_\_\_\_
3. Please list the members of your household by age and indicate their health status - e.g. **Good, Fair or Poor.**

Age	Health Status

Age	Health Status

4. Does any member of your household use **mobility aids** such as a wheelchair, crutches, or a walker on a consistent basis?

Age of household member	Type of equipment used	Homebound: YES or NO

5. In an emergency situation requiring evacuation of households, would you need assistance to evacuate yourself and/or other members of your household?

Check (X): **YES** \_\_\_\_\_ or **NO** \_\_\_\_\_  
**Emergency Needs Community Survey** continued

6. Does **any** member of your household have **one** or **more** of the following health problems which might require medical attention in the event of a prolonged emergency? **Please check (X) YES or NO for each of the health problems listed below.**

Health Problem	YES	NO
Insulin dependent diabetes		
Renal dialysis		
Oxygen dependent lung disease		
Severe heart disease		
Advanced cancer/hospice care		
Seizure disorder		
Severe asthma		
Other (please specify):		

7. Does any member of your household require:

a. **daily** access to life sustaining medications such as insulin, blood thinners...?

Check (X) one: YES \_\_\_\_\_ NO \_\_\_\_\_

b. **access in emergency situations:** such as epinephrine for allergic reactions

Check (X) one: YES \_\_\_\_\_ NO \_\_\_\_\_

8. If you answered **YES** to Question # 7, do you keep an emergency supply of these medications on hand for use in a prolonged emergency?

Check (X) one: YES \_\_\_\_\_ NO \_\_\_\_\_

9. Is any member of your household on **life support equipment**? If so, please indicate the type of equipment and whether or not you have a back-up power supply in the event of a sustained power failure. Examples of such equipment include ventilators, apnea monitors, home dialysis machines...

Type of equipment - e.g. ventilator...	Back-up power source: YES or NO for each piece of equipment.	How long can the back-up power supply keep the equipment operating?

10. If you live alone and/or have a household member who is homebound and wish to provide information on an **emergency contact**, please do so below.

Name (please print): \_\_\_\_\_

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

Telephone Numbers - (home): \_\_\_\_\_

(work) : \_\_\_\_\_ (cell and/or pager): \_\_\_\_\_