TOWNSHIP OF VERONA EMERGENCY CONTACT REGISTRATION FORM

Name:	
Address:	**APT #:**
Phone:	**Date Of Birth:**
Doctor:	
Prefered Hospital:	
PERSONS TO CONTACT IN CASE OF EMERGENCY	
Name:	**Relationship**
Address:	
Home Phone:	**Cell Phone:**
Name:	**Relationship**
Address:	
Home Phone:	**Cell Phone:**
Name:	**Relationship**
Address:	
Home Phone:	**Cell Phone:**
CIRCLE ANY DISABLITIES YOU MAY HAVE	
Wheelchair Bound	**Bedbound**
Walker	**Cane**
Hearing Impaired	**Deaf**
Visually Impaired	**Blind**
Mentally/Memory Impaired	**Dementia/Alzheimer's**
Developemental Disability	**Autism Spectrum Disorder**
Oxygen Dependant	**Diabetic**
Other: (Please be specific)	
Do you live alone? YES NO	
Do you have Lifeline or other Emergency Alerting Device? YES NO	
Have you or a family member signed up for Nixle Alerts? YES NO	
Do you have a service animal? YES NO	
Do you require an medical equipment that is not easily transportable or requires electricity? YES NO. If yes please identify equipment below.	
Please list any other information about yourself which would be helpful to emergency responders.	
Form Completed by:	**Date:**

Return completed form to
Verona Police Department, 600 Bloomfield Avenue, Verona NJ 07044 OR
Verona Health Department, 880 Bloomfield Ave, Verona NJ 07044