

AMERICAN RED CROSS

First Name _____

Last Name _____

Address: Apt# _____ Floor# _____

Cell Phone # (____) _____

Street Address _____

Alt Phone # (____) _____

City/State/Zip _____

E-Mail _____

Date of Birth: ____/____/____

Will you be the Primary Point of Contact for Red Cross? Yes/No

If not, who is? _____

Do you have ID with you? Yes/No

What type? _____

Do you have Homeowner's or Renters Insurance? Yes/No

Do you have a place to stay tonight? Yes/No Next few nights? Yes/No

Do you have any medical needs due to the disaster, including missing medication, medical equipment, eyeglasses, dentures, hearing aids, etc? Yes/No

Do you have any pets? Yes/No How many? ____ Are they missing? Yes/No

Do you have any special dietary needs or food allergies, ie. gluten free, vegetarian, etc Yes/No

What are they? _____

Other members of your household living at the same address:

First Name	Last Name	Gender	Relationship to Primary Client	Date of Birth (mm/dd/yyyy)

(Write on back if there are more family members.)

Notes for Red Cross:
