**Developmental Disability Registry**

The Columbiana County Board of Developmental Disabilities (CCBDD), in partnership with First Responders in Columbiana County are committed to ensure the health, safety, and wellness of our individuals.

Participation in this program is voluntary and information will remain confidential unless its release is required by law. First Responders will be alerted to this information if they are called to provide services to you in your home or the community. You may choose not to answer any portion of the attached form and you may withdraw from this program by notifying the CCBDD at any time. You will be asked to update this information occasionally to ensure the First Responders have the most current and accurate information available.

Name (Individual Served): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Middle

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Home):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: 🞎 Male 🞎 Female 🞎 Non-Binary

 (MM/DD/YYYY)

Height: \_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_Hair Color \_\_\_\_\_\_\_\_\_\_ Eye Color: \_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_ Glasses: (Y/N)

**DIAGNOSIS:** **SENSORY/COMMUNICATION:**  **MOBILITY:**

🞎 Autism 🞎 Non-Verbal 🞎 Ambulatory

🞎 Developmental Disability 🞎 Speech Assistance 🞎 Uses a Walker

🞎 Cerebral Palsy 🞎 Device Hearing Impaired 🞎 Uses a Wheelchair

🞎 Traumatic Brain Injury 🞎 Vision Impaired 🞎 Confined to a bed-

🞎 Co-occurring Mental Health Provide location in home\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe any TRIGGERS which affect the individual (Examples: loud noises, bright lights, etc.)**

**Describe any LIFE THREATEING issues/concerns & medical devices (Examples: Diabetes, choking hazard, seizures, oxygen, ventilator, etc.)**

**Describe any CALMING METHODS used for the individual:**

**Does the individual gravitate toward any particular Location? (Examples: water, playground, woods, etc.):**

**Additional information (Example: Special Instructions to get into the home):**

 Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Columbiana County Board of Developmental Disabilities-24 hour Emergency Number (SSA on Call): 330-424-7767**

**In addition to sharing information with Columbiana County First Responders, CCBDD may share information designated on this form to the following agencies. (This information is only shared on a voluntary basis and is not required)**

\_\_\_\_\_Columbiana County Mental Health and Recovery Services Board

\_\_\_\_\_Columbiana County Counseling Center

\_\_\_\_\_Columbiana County Dept. of Jobs and Family Services

\_\_\_\_\_Community Action Agency (CAA)

\_\_\_\_\_CommQuest

\_\_\_\_\_East Liverpool City Hospital

\_\_\_\_\_Family Recovery Center

\_\_\_\_\_New Vision Services

\_\_\_\_\_Opportunities for Ohioans with Disabilities (OOD)

\_\_\_\_\_Salem Regional Medical Center

\_\_\_\_\_ Comprehensive Behavioral Health

\_\_\_\_\_ Mercy – St E’s Hospital.

\_\_\_\_\_ Generations

\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing this form, I agree to permit the information contained herein to be shared with Columbiana County First Responders. I understand that this is a voluntary program and that I may choose not to participate or not to answer all of the questions. I understand while the sharing of this information will better assist me in an emergency situation or encounter-it does not guarantee safety in every circumstance.**

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Individual: (Parent/Guardian)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Internal Use Only:**

**Date Received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sent to CCEMA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**