**PINELLAS COUNTY EVACUATION ASSISTANCE/SPECIAL NEEDS REGISTRATION**

**Registration for:** ☐**Special Needs Shelter** ☐**Transport Assistance** ☐**Both**

*Once this registration form is processed, you will be contacted by your local Fire Department*

LAST: _____ FIRST: _____ Date of Birth: ____/____/____ ☐Male ☐Female

STREET ADDRESS: _____ APT#_____ LOT#:_____

CITY: _____ ZIP:_____ PHONE:_____

**I REQUIRE TRANSPORTATION ASSISTANCE**: ◯YES ◯NO **LIVING SITUATION**: ☐ALONE ☐RELATIVE ☐OTHER

☐SINGLE FAMILY RESIDENCE ☐MOBILE HOME ☐APT/CONDO COMPLEX NAME:_____

☐CARETAKER: _____ PHONE NUMBER: _____ ☐HOSPICE: _____, TEAM ID:_____

☐ HOME HEALTH:_____ PHONE NUMBER: _____ HOSPICE PHONE NUMBER :_____

DO YOU HAVE A PET:◯YES ◯NO ☐Arrangements for pets completed. Call 727-582-2600 for details

**SPECIAL NEED (CHECK ALL THAT APPLY)** Questions? Call Health Department – 538-7277 ext. 7916

- ☐ **Kidney Disease**
- ☐ **Dialysis**
  - ☐ *Center:_____*
  - ☐ *Days a Week:_____*
- ☐ **Diabetes**
  - ☐ *Insulin Dependent*
  - ☐ *Oral Medication (pills)*
- ☐ **High Blood Pressure**
- ☐ **Heart Disease**
- ☐ **Stroke**
  - ☐ *No problems*
  - ☐ *Needs assistance*
- ☐ **Speech Impaired**
- ☐ **Cancer:**
  - ☐ *Year_____*
  - ☐ *On Chemotherapy now*
  - ☐ *On Radiation now*
- ☐ **Asthma**
- ☐ **Emphysema**
- ☐ **COPD**
- ☐ **Breathing Treatment**
- ☐ **Oxygen: _____LPM**
- ☐ **Ventilator**

  ***Can not breathe on your own***
- ☐ **Mental Health Impaired**
  - ☐ *Schizophrenia*
  - ☐ *Obsessive Compulsive*
  - ☐ *Violent Behavior*
  - ☐ *Other:_____*
- ☐ **Memory Impaired**
- ☐ **Sight Impaired**
  - ☐ *Wears Glasses*
  - ☐ *Blind*
- ☐ **Service Dog**
- ☐ **Hearing Impaired**
  - ☐ *Hard of Hearing*
  - ☐ *Deaf*
- ☐ **Walker/Cane**
- ☐ **Wheelchair user**
  - ☐ *Able to stand with help*
  - ☐ *Unable to stand*
- ☐ **Bedridden only**
- ☐ **Geri Chair**
- ☐ **Incontinence**
  - ☐ *Occasionally*
  - ☐ *Wear adult diapers*
- ☐ **Feeding Tube**
  - ☐ *Unable to swallow***
  - ☐ *24 hour feedings***
  - ☐ *For medications only*
  - ☐ *Syringe feedings only*

****24 Hour Tube Feedings or unable to swallow needs to go to a hospital or nursing home**

**Electrical Dependent, Why?**
- ☐ **CPAP/BiPAP**
- ☐ **Electric Wheelchair/Scooter**
- ☐ **Nebulizer** (breathing treatment)
- ☐ **Oxygen Concentrator**
- ☐ **Feeding Tube**
- ☐ **Other:_____**

☐ **Other Special Needs:**

_____

_____

_____

_____

***MANDATORY SpNS***

***Dialysis, Oxygen, Breathing Treatment, Feeding Tube (syringe feedings or for medications only)***

***Bring all supplies to SpNS***

☐ ***NONE***

**Emergency Contacts**

NAME: _____ RELATIONSHIP:_____ PHONE:_____

NAME: _____ RELATIONSHIP:_____ PHONE:_____

Prearranged: ☐Hospital:_____ ☐Nursing Home:_____ ☐ALF:_____ ☐ Other:_____

NAME: _____ RELATIONSHIP:_____ PHONE:_____

Doctor's name: _____ _____ PHONE:_____

**Form completed by** (PRINT NEATLY): _____ Relationship: _____ Phone #_____

By signing this form I give my authorization for the medical information contained herein to be released to the county health department, emergency management, local fire districts and receiving facilities for the purpose of evaluating my needs and providing emergency transportation and sheltering. Records relating to registration of disabled citizens are exempt for the provisions of F.S. 119.07(1), Public Records Law. The information contained here will be kept confidential.

_____ _____

Signature Date

**Official use only**

**Transport to:** ☐General Shelter ☐Special Needs Shelter ☐Other _____ ☐Register for Special Needs Shelter Only

**Type of Transport:** ☐ Own vehicle ☐ Van/Bus ☐ Wheelchair only ☐ Ambulance

Fire Dist:_____ Grid:_____ Evac Level: _____ Shelter Name:_____

**Comments:**_____

**Mail completed form to: Office of Emergency Management, 10750 Ulmerton Rd. Building 1, Suite 267, Largo, FL 33778 or fax to 727-464-4024.**

**For more information please call 727-464-3800. Rev 07/28/14**