

2010-2011 SPECIAL NEEDS REGISTRATION FORM
COLLIER COUNTY EMERGENCY MANAGEMENT

REGISTRANT INFORMATION- PLEASE PRINT OR TYPE THE INFORMATION
AND COMPLETE BOTH SIDES OF EACH PAGE AND THE MEDICATION SHEET. A NEW
REGISTRATION FORM IS REQUIRED EVERY YEAR.

Only the information about the Person with Special Needs is filled out on this form. If you are an accompanying caregiver with no Special Needs you do not need to fill out a form for yourself. You will be listed with the registered person. Thank you

Name: _____ Spouse or Parent Name: _____
Last First MI

Home Address: _____ Apt. _____ Bldg. _____

City: _____ Zip code 341 _____ Phone: (239) _____ Cell phone: () _____

Mailing Address: (if different from home address) _____

Answering machine: YES NO Email Address: _____

(If applicable) Hearing Impaired TDD # () _____

Do you use a Video Phone: YES NO Do you use Florida Relay 711: YES NO

Do you use ASL? YES NO

Residence type: Single Family Home _____ Subdivision Name: _____

Manufactured Home _____ Park Name: _____ Lot # _____

Apartment / Condo _____ Complex Name: _____ Floor _____

Date of Birth: _____ Age _____ Language Spoken: _____ Sex: Male Female

Year round resident? YES _____
NO _____

If "NO", in Collier County from _____ to _____
Month Month

TRANSPORTATION

Choose one of the following modes of transportation

_____ I have a ride to the Special Needs Shelter How many people going to the shelter _____

_____ I need a ride to the Special Needs Shelter Number of people to pick up _____

ASSISTANCE NEEDED- Circle the one most appropriate

None Arm/Frail Cane Walker Wheelchair Electric Scooter Stretcher/Bedridden

(You will need to provide your own cane, walker, wheelchair or scooter and make sure your name is on it)

If using a wheelchair, can you transfer to the seat on the bus? YES NO Do you use a Hoyer Lift? YES NO

If a Stretcher is needed, explain why _____

Equipment your life depends on that must be transported with you: _____

Please list equipment that requires electricity: _____

HOME CARE INFORMATION- please choose from selection listed

I take care of myself at home I need part time nursing help at home
 I am unable to care for myself at home I have 24 hr paid services at home
 I have a Supported Living Coach

LIVING ARRANGEMENT- please choose from selection listed

I live alone I live with family / friends

DOCTOR AND HOME HEALTH INFORMATION- MUST BE FILLED OUT

Primary Doctor _____ Phone () _____
(Print Doctors Name Please)

Home Health Agency providing home care: _____ Phone () _____

PETS

Please list # of each: None _____ (Cat _____) (Dog _____) (Bird _____) (Other _____)

Have you made arrangements to shelter your pet in an emergency while you are at a shelter? YES or NO

Do you have a pet carrier for each animal? YES or NO Does your pet have a microchip? YES or NO

Veterinarian's Name: _____ Veterinarian's phone number: _____

SHELTER INFORMATION

The following person will be taking care of me in the shelter: _____

Relationship of caregiver to registrant & caregiver phone number: _____

In case of emergency call: _____ Phone () _____

Office Phone () _____ ext. _____ Cell Phone () _____

Should your home sustain damage and you are not able to immediately return home, what will be your plan for sheltering? Please list who should be contacted and/or with whom you would stay. List local and out of the area contacts. If possible do not list the same person you put down for your emergency contact.

Contact Person: _____ Phone Number: () _____

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Sheltering Plan after an event:

CIRCLE ANSWER OR FILL IN THE ANSWER
ONLY FOR THE PERSON REGISTERING

(Attach additional paper if necessary)

Hard of Hearing	YES / NO	Hearing Aids	Right Ear / Left Ear / BOTH
Macular Degeneration	YES / NO	Legally Blind	YES / NO
Do you normally wear glasses or contacts	YES / NO	Do you use reading glasses	YES / NO
Do you normally need assistance with activities of daily living?	YES / NO		
I can walk only a limited distance	YES / NO		
Quadriplegic or Paraplegic/ Amputee	Use a service animal YES / NO		
Confusion / Dementia / Early Alzheimer's / Advanced Alzheimer's / Prone to wander / Combative			
Foley Catheter or Ostomy: if yes please list what type			
Psychological Needs	YES / NO		
Developmentally Disabled or Neurological Disorder: (Please list)			
Seizures:	YES / NO		
Name of Oxygen Provider	_____	Do you use liquid oxygen	YES / NO
Liter Flow	_____ lpm	Hrs per Day	_____
Do you have a concentrator	YES / NO	**YOU MUST BRING YOUR CONCENTRATOR**	
Nebulizer treatments	YES / NO	How many treatments per day:	_____
Apnea monitor / C PAP / BI PAP	Ventilator or Tracheostomy Tube YES / NO		
Diabetes	YES / NO	Use Insulin	YES / NO
Dressing Changes or / Wound Care Assistance YES / NO			
Feeding Tube	YES / NO	Infusion/ IV Therapy	YES / NO
Injectable Medication	YES / NO		
Needs assistance or supervision with medications, IM or IV injections:			YES / NO
Peritoneal Dialysis or Hemodialysis			
What days of the Week do you go to Dialysis : Sun, Mon, Tues, Wed, Thurs, Fri, Sat (circle days)			
Name & Phone Number of Dialysis Center			
Cardiac: CHF, Angina, Hypertension, Stroke, Implanted Defibrillator, Pacemaker (Please List)			
Immune System Problems (Hepatitis, TB, Cancer, etc) (Please List)			
Terminal Illness	YES / NO	Living Will	YES / NO
Do you have DNR papers?	YES / NO		
Do you have a cot to bring to the shelter?	YES / NO		
Registrant's weight	_____ lbs	Height	_____ feet _____ inches

IMPORTANT NOTICE AND STATEMENT OF UNDERSTANDING

The information contained herein is true and correct to the best of my knowledge. I have read and understand the information on this form as well as the attached Evacuation and Special Needs Sheltering Information sheet.

I understand that: The registration is **voluntary** and hereby request registration in the "Special Needs Shelter" (PSN) program.

- Emergency shelters are made available to provide protection during the immediate danger.
- I am responsible to PROVIDE A CAREGIVER WHILE AT THE SHELTER IF I AM UNABLE TO CARE FOR MY OWN BASIC & SPECIAL NEEDS.
- I have a copy of the PREPARATION GUIDELINES and will take with me the things that I need.
- LIMITED volunteer nursing and medical assistance in the Special Needs Shelter will be available to assist me and/or my caregiver.
- **I will need to make alternative arrangements in the event that I am unable to return to my home after the storm.**
- I will be responsible for any charges and costs associated with hospitalization or other medical facility including care and medical transportation, if they should become needed.
- **TRANSPORTATION:** I may be ordered or recommended to evacuate my residence. All attempts will be made to give advance notice by phone of the date and time expected to be picked up for transport to the Special Needs Shelter. Monitor government TV (Channel 97), Local TV stations or Local Radio Stations for updated hurricane information. **IF I DECLINE TRANSPORTATION** when the transporter arrives, I will be required to sign a "**Refusal Form**". I understand that upon declining transportation, I may not have another opportunity to request this service.

I grant permission to health care providers, transportation agencies, and others as necessary to provide care, and to disclose any information that is necessary to respond to my needs.

I authorize emergency response agencies to enter my residence for the purpose of emergency search and rescue. Yes / No

 Signature of Responsible Party / Relationship to Registrant Date _____
** Form must have a signature **

Please complete this form and mail to: Collier County Emergency Management
 ATTN: PSN
 8075 Lely Cultural Pkwy, Suite 445
 Naples, FL 34113

