

2009-2010 SPECIAL NEEDS REGISTRATION FORM
COLLIER COUNTY EMERGENCY MANAGEMENT

REGISTRANT INFORMATION- PLEASE PRINT OR TYPE INFORMATION
AND COMPLETE ALL SECTIONS

Only the person with Special Needs should fill out a form. If you are an accompanying spouse or parent 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

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 (we) will drive to the shelter. How many people going to the shelter _____

_____ I (we) need transportation. Number of people to pick up _____

ASSISTANCE NEEDED

None Arm/Frail Cane Walker Wheelchair Electric Scooter Stretcher

(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 _____
NO _____

Do you have a pet carrier for each animal? YES _____ NO _____

SHELTER INFORMATION

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

Relationship of caregiver to registrant at shelter: _____

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.

Contact Person: _____ Phone Number: () _____

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Contact Person: _____ Phone Number: () _____

Sheltering Plan after an event:

<p><u>CIRCLE ANSWER OR FILL IN THE ANSWER FOR ONLY THE PERSON REGISTERING</u></p> <p>(Attach additional paper if necessary)</p>	<p>LIST YOUR <u>ALLERGIES AND MEDICATIONS</u></p> <p><u>PRINT</u></p> <p>THE NAME OF YOUR DOCTOR, MEDICATION AND THE DOSAGE</p> <p>(Attach additional paper if necessary)</p>
Hard of Hearing: YES / NO Hearing Aids: Right Ear / Left Ear / BOTH	Allergies
Macular Degeneration: YES / NO Do you wear glasses: YES / NO Legally Blind: YES / NO	
Do you normally need assistance with activities of daily living? YES / NO	Pharmacy & Phone Number
Quadriplegic or Paraplegic: Circle if applicable	Medications
Dementia, Early Alzheimer's, Advanced Alzheimer's	1.
Ostomy: if yes what type-	2.
Confusion or Psychological Needs YES / NO	3.
Seizures YES / NO	4.
Name of Oxygen Provider: _____	5.
Do you use liquid oxygen YES / NO	
Liter Flow _____ lpm	6.
Hrs per Day _____	
Do you have a concentrator YES / NO **MUST BRING YOUR CONCENTRATOR**	7.
Nebulizer treatments YES / NO	8.
How many treatments per day: _____	
Apnea monitor, C PAP, BI PAP	9.
Ventilator or Tracheotomy Tube YES / NO	10.
Diabetes: YES / NO Use Insulin: YES / NO	11.
Dressing Changes or /Wound Care Assistance YES / NO	12.
Feeding Tube YES / NO	13.
Injectable Medication YES / NO	
Infusion/ IV Therapy YES / NO	
Developmentally Disabled or Neurological Disorder (Please list)	14.
Peritoneal Dialysis or Hemodialysis	15.
What days of the Week you go to Dialysis Sun, Mon, Tues, Wed, Thurs, Fri, Sat (circle days)	16.
Name & Phone Number of Dialysis Center	17.
Cardiac: CHF, Angina, Hypertension, Stroke, Pacemaker (Please List)	18.
Immune System Problems- (Hepatitis, TB, Cancer) (Please List)	19.
Terminal Illness: YES / NO Living Will: YES / NO Do you have DNR papers? YES / NO	20.
Do you have a cot to bring to the shelter? YES / NO	21.
Registrant's weight: _____ lbs Height: _____	22.

IMPORTANT NOTICE AND STATEMENT OF UNDERSTANDING
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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:

- Emergency shelters are made available to provide protection during the immediate danger.
- I am responsible to PROVIDE FOR MY OWN BASIC & SPECIAL NEEDS while in the shelter.
- 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 health care section of the 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 to expect to be picked up for transport to a shelter. Monitor government TV and local TV 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 understand that this registration is voluntary and hereby request registration in the "Special Needs Shelter" (PSN) program.

(I Authorize) (I DO NOT Authorize) that Emergency Personnel may enter my home during Search and Rescue operations if necessary to assure my safety and welfare following a disaster.

Signature of Responsible Party / Relationship to Registrant

Date _____
** Form must have a signature **

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