

# PUTNAM COUNTY SPECIAL NEEDS EVACUATION SHELTER REGISTRATION FORM



INSTRUCTIONS: Required by F.S., this form is to assist the Putnam County Emergency Operations Center provide assistance to those citizens of Putnam County that have special needs during a declared State of Emergency. If you are a person with a special need and are a client of a local home health care agency, you may wish to coordinate the completion of this form with your visiting professional. **Annual/yearly registration is required no later than the date of application each year.** Please return this form to the following address: NURSING DIRECTOR, PUTNAM COUNTY HEALTH DEPARTMENT, SPECIAL NEEDS REGISTRATION, 2801 KENNEDY STREET, PALATKA, FL. 32177

## PERSONAL INFORMATION:

New Registrant: Yes  No  Registrant Yearly Update: Yes  No  Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last
First
Middle

Physical Residential Address: \_\_\_\_\_  
Number/Apt.
Street
City
Zip

Mailing Address: \_\_\_\_\_  
Number/Apt.
Street
City
Zip

Patient Telephone: \_\_\_\_\_ / \_\_\_\_\_  
Area Code/ Number
Alternate Number (cell phone, etc.)

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex:  Male  Female

Primary Language: \_\_\_\_\_ Currently Sleep on: Hospital Bed  Regular Bed

Living Situation: Live Alone  With Spouse  With Parents  With dependant under 18 yrs old  Other

Type of Living Unit:      Manufactured Home       Site built home /Modular home       RV

## SHELTER CAREGIVER INFORMATION:

Name: \_\_\_\_\_  
Last
First
Middle

Physical Residential Address: \_\_\_\_\_  
Number/Apt.
Street
City
Zip

Caregiver Telephone: \_\_\_\_\_  
Area Code/ Number
Alternate Number (cell phone, etc.)

Caregiver Relationship: \_\_\_\_\_ Caregiver Occupation: \_\_\_\_\_

**EVACUATION TRANSPORTATION:**

Do you need transportation to the Special Needs shelter in the event of disaster? Yes  No

If "Yes," mark one: Currently transported by: Wheelchair Van:  Car/Bus:  Ambulance:

*Please Note: Transportation and shelter will be provided ONLY for you plus one caregiver. Each Caregiver is required to accompany each patient to the Special Need Shelter.*

**ATTENTION PET OWNERS:** Plan for pets prior to an emergency. Emergency Shelters will not allow pets - except for service animals.

**PRE-AUTHORIZATION FOR DIASTER SEARCH AND RESCUE**

By submittal of this form you pre-authorize emergency response personnel to enter my home during search and rescue operations to assure my safety and welfare.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

**DIAGNOSES:** \_\_\_\_\_

Primary Doctor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICAL CARE INFORMATION** (PLEASE CIRCLE/MARK ONLY THOSE THAT APPLY)  
**(YOU MUST BRING ALL YOUR OWN MEDICATION, EQUIPMENT AND MEDICAL SUPPLIES WITH YOU)**

- Respirator Dependent
- Dialysis Dependent
- Sight Impaired
- Blind
- Speech Impaired
- Hearing Impaired
- Mobility Impaired
- Medical Dependence on Electricity
- Tracheotomy (date preformed: \_\_\_\_\_) Suction Required \_\_\_\_\_
- Cardiac History (date(s): \_\_\_\_\_)  Amputee (date: \_\_\_\_\_)
- Simple non-sterile  Complex sterile  Memory Impaired  Senile  Alzheimer
- Incontinence  Bowel  Bladder  Tube Feeding (Bring 4 days Supply)
- IV Therapy
- Foley Catheter
- Ostomy Care
- Oxygen Dependent
- Nebulizer Therapy
- Diabetic Oral \_\_\_\_\_ Insulin \_\_\_\_\_  Special Dietary Needs
- Wheelchair Bound  Bed Bound
- Allergies
- Dressings
- Hospice Care
- Walker  Cane

List all medications currently taking (use another sheet if necessary) including dose and frequency:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_