

CLAY COUNTY DIVISION OF EMERGENCY MANAGEMENT



SPECIAL NEEDS/ EVACUATION REGISTRATION

This program is designed for those who have special medical needs and may require shelter and/or evacuation assistance in the event of an emergency. If you anticipate the need for evacuation, you should make arrangements to shelter with relatives, friends or community organizations. If you require special/ambulance transportation and/or hospital facilities you or your care giver should make those arrangements ahead of time. The Special Needs Shelter will only be available as a **last resort** for people who have no other place to go. In an actual emergency, response agencies will try to provide the necessary assistance, but this cannot always be assured. Registered individuals planning to go the Special Needs Shelter should be accompanied by their personal care giver.

The management of nursing, convalescent, retirement and other group facilities are responsible for the evacuation and sheltering of their own residents.

The program requires you to **enroll annually**. Please complete this registration and mail it to the following address: Clay County Division of Emergency Management, **P.O. Box 1366**, Green Cove Springs, FL 32043. This application may also be faxed to 904-529-2273. For more information, please call 904-284-7703 or 1-877-252-9362 (toll free).

All information contained in this form is confidential and exempt from disclosure and can be made available only to other emergency response agencies (Section 252.355, Florida Statute)

Please Print Clearly

PERSONAL ENROLLMENT DATA

DATE OF REGISTRATION: _____

Sex: ___M or ___F

Name: _____
Last First Middle

Address: _____
Street City Zip

Telephone: _____ Date of Birth: _____ Age: _____

What language(s) do you speak? _____

Residence Type: House/Duplex Mobile Home/Trailer Apt/Condo

Living Situation: Living Alone W/ Spouse W/ Spouse & Children W/Parent(s)

W/ Child(ren) - Age(s) _____ W/ Other Relative W/ Non-Relative

MEDICAL CARE INFORMATION

Special Medical Needs (check those that apply):

Medical Dependence on Electricity Memory Impaired Anxiety/Depression

Mental Health Impaired Respirator Dependent Dialysis Dependent

Diabetes Speech Impaired Emergency Alert Monitors

- Wheelchair Dependent
- Bedridden
- Dependant on a Walker
- Dependant on a Cane
- Hearing Impaired
- Incontinence
- Daily Dressing Changes
- Sight Impaired
- Tracheotomy
- Colostomy
- Intravenous Line
- Foley Catheter
- Acute/Chronic Respiratory Problems

-Type of Oxygen Used: Tank Room Air Machine

Oxygen Company: _____

Other: _____

Medical Problems: _____

Allergies: _____

Medications: _____

Medical Equipment: _____

Primary Doctor Name: _____ Telephone: _____

Home Health Agency Name: _____ Telephone: _____

Pharmacy Name: _____ Telephone: _____

EMERGENCY CONTACTS:

(Personal Care Giver) Name: _____ Relationship: _____ Telephone: _____

(Non-Local) Name: _____ Relationship: _____ Telephone: _____

Name of care giver accompanying you to the shelter: _____

Your personal Care Giver assists you with:

- Personal Care (Dressing/Toileting)
- Feeding
- Taking Medicine
- Other _____

ASSISTANCE REQUIRED:

Do you have transportation to a Shelter? Yes No

What type transportation do you need? Bus Wheelchair Van Ambulance (To hospital only)

Do you have a service animal? Yes No What kind? _____

THIS SECTION TO BE COMPLETED BY THE EMERGENCY MANAGEMENT OFFICE

Date Rec'd _____ Date Updated _____ Date Triaged _____ Level of Care _____