PINELLAS COUNTY EVACUATION ASSISTANCE/SPECIAL NEEDS REGISTRATION
Registration for: ☐Special Needs Shelter ☐Transport Assistance ☐Both
Once this registration form is processed, your local Fire Department will contact you.

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. ☐ Registered with PC Animal Services: 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** ***Cannot 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** ☐ **Allergies:** _____.	**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: _____Level: _____ Shelter Name: _____.

Comments: _____.

Mail completed form to: Office of Emergency Management, 400 S. Ft. Harrison Ave. Suite 111, Clearwater Fl 33756 or fax to 727-464-4024.
For more information please call 727-464-3800. Rev 1/23/12