

Florida Special Needs Registry – Personal Survey Form

Your Personal Information

If your address does not reflect your actual physical location, then describe where the location is that emergency personnel can find you.

First Name: _____ MI: _____ Last Name: _____ Suffix: _____

Email: _____

The email address will be utilized to provide annual reminders to update information.

Physical Address:

Please enter the exact full street address ONLY in the space provided (e.g. 123 Anywhere Street). Please enter P.O. Boxes or R.R. #s on the ADDRESS 2 line.

Address: _____

Apt #: _____

City: _____ State: _____ Zip Code: _____

County: _____ Municipality: _____

Mailing Address (Please enter if different than physical address):

Address: _____

Apt #: _____ P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Ext.: _____

Is Primary Phone TTY/TTD (Teletype Device): Yes No

Secondary Phone: _____ Ext.: _____

I do not have a phone

Date of Birth (MM/DD/YYYY): _____

Height: (Feet) _____ (Inches) _____ Weight: _____

Why do you need my height and weight?

It is important that emergency responders be aware of any condition you have that requires either special equipment or additional personnel to safely evacuate you. This includes gathering information on your size (both height and weight).

Gender (Check one): Male Female Eye Color: _____

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Emergency Contact Information

Please provide contact information for an individual with whom we can discuss your situation in the event that an emergency necessitates this. If you would rather not provide an emergency contact, please check:

I choose not to provide emergency contact information.

Primary Contact:

First Name: _____ MI: _____ Last Name: _____ Suffix: _____

Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Emergency contact's relationship to you (check one):

None Friend Family Member Neighbor Caregiver Other

Email: _____

Primary Phone: _____ Ext.: _____

Secondary Phone: _____ Ext.: _____

Checking this box allows medical information to be shared with this emergency contact.

Secondary Contact (Please enter an out-of-area contact):

First Name: _____ MI: _____ Last Name: _____ Suffix: _____

Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Emergency contact's relationship to you (check one):

None Friend Family Member Neighbor Caregiver Other

Email: _____

Primary Phone: _____ Ext.: _____

Secondary Phone: _____ Ext.: _____

Checking this box allows medical information to be shared with this emergency contact.

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Additional Contact Information:

Physician Information:

Name: _____ Phone: _____ Ext. _____

Home Health Care Information:

Name: _____ Phone: _____ Ext. _____

Caregiver Information:

Name: _____ Phone: _____ Ext. _____

Pharmacy Information:

Name: _____ Phone: _____ Ext. _____

Home Medical Equipment Provider Information:

Name: _____ Phone: _____ Ext. _____

Dialysis Center Information:

Name: _____ Phone: _____ Ext. _____

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Evacuation Information

If there were an emergency requiring evacuation, you may have difficulty evacuating or being notified of the need for evacuation because of the following conditions (check all that apply):

- Blind/Low Vision
- Deaf/Hard of Hearing
- Behavioral Health Issues
- Contagious Disease
- Frail / Elderly
- Speech Impediment
- Physical Disability (Please Explain): _____
- Bedridden
- Mentally/Memory Impaired
- Dementia/Alzheimer's *Full-time caregiver must be present at all times during stay at shelter* (Please indicate Mild, Moderate or Severe) _____
- Dialysis (Please indicate Hemodialysis at Facility, Hemodialysis at Home or Peritoneal) _____

- Requires Constant Skilled Nursing Care (e.g., open wounds)
- Assistance with Medications
- Assistance Needed with Insulin
- Requires Refrigerated Medications
- Medications (Please list all required medications): _____

- Autism
- Special Dietary Needs/Restrictions (Please Explain): _____

- Seizures
- Other Reason for Needing Assistance (Please Specify): _____

Transportation Needs:

*If transportation assistance is required, **please check all** vehicle types that can be used for transportation.*

- Car
- Bus
- Wheelchair Van
- Ambulance

Communication Limitations (Check all that apply):

- I do not have a radio
- I do not have a television
- I do not have a telephone, TTY or VRI
- I do not have access to the Internet
- I do not speak English (Provide language you speak): _____

How do you receive emergency notifications? _____

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Has difficulty walking and requires:

- Walker/cane
- Standard wheelchair
- Motorized wheelchair
- Motorized Scooter
- Attendant to assist in walking
- Requires Stretcher Transportation
- Hoyer Lift

Oxygen Dependent:

Check all that apply:

- 24 Hour (Please specify O2 Type, Liters Flow, O2 Company and Contact Information):

- Only Overnight (Please specify O2 Type, Liters Flow, O2 Company and Contact Information):

- Nebulizer (Please specify O2 Type, Liters Flow, O2 Company and Contact Information):

- CPAP (Please specify O2 Type, Liters Flow, O2 Company and Contact Information):

- Other (Please specify O2 Type, Liters Flow, O2 Company and Contact Information):

Requires medical equipment that is not easily transportable:

- Ventilator
- Suction machine
- Catheters
- Feeding Tube
- Oxygen Concentrator
- Other equipment (Please Specify): _____

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Required Assistance

This information will be helpful in determining the assistance that the person requires.

1. Are ALL of the support needs resulting in the need for evacuation assistance temporary?
 (Example: The individual is bedridden due to pregnancy difficulties, but is expected to be fully recovered after the baby is delivered.)

Check One: Yes No, the condition(s) are expected to be permanent.

Please provide an estimated date when the condition will be resolved

Month: _____ Year: _____

2. Is the person in need a seasonal resident? Yes No

Date From: _____ Date To: _____

3. Does the person in need require evacuation assistance 24 hours a day?

Check One: Yes No

If you do **not** require evacuation assistance 24 hours a day, when do you need help?

(Enter time below.)

Time From: _____ a.m. p.m. Time To: _____ a.m. p.m.

4. Does the person in need have a 24 hour caregiver? Yes No

Will the caregiver travel and stay with you? Yes No

Service Animals/Pets:

Please list any Service Animals / Pets in your care that will also require assistance.

According to Florida Statute 413.08 a "service animal" means an animal that is trained to perform tasks for an individual with a disability. The tasks may include, but are not limited to, guiding a person who is visually impaired or blind, alerting a person who is deaf or hard of hearing, pulling a wheelchair, assisting with mobility or balance, alerting and protecting a person who is having a seizure, retrieving objects, or performing other special tasks. A service animal is not a pet..

Service Animal Y/N	Name	Type	Breed / Description	Weight	Carrier Cage? Y/N	Leash? Y/N	Muzzle? Y/N

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Additional Comments/Information

Please enter any additional information (e.g.: medical conditions, medications, allergies, etc) that may be useful for our emergency personnel who will be assisting you during an evacuation.

Thank you for completing your special needs survey. The information you provided will be of great value in helping emergency responders plan for the safety of the individuals with special needs in our community. It is crucial to our response efforts that the information you provide be as accurate and up to date as possible. You will be emailed periodically to verify and ensure the information provided is correct and to make any necessary changes. Individual surveys will be archived after one year if not verified.

Completing the Florida Special Needs Registry does not automatically qualify the individual for a special needs shelter. Additional information will be provided by your local emergency management agency regarding sheltering.



REMEMBER: Floridians are encouraged to prepare for all types of emergencies. Building an individual or family emergency plan is the first step. During an emergency, the government and other agencies may not be able to meet your needs. You should be prepared to take care of yourself and loved ones for a minimum of 72 hours. Those individuals with a special need are encouraged to identify an emergency support network and to build a disaster supply kit. For more information on planning visit www.FLGetAPlan.com to build your individual or family emergency plan.

By signing this form I give my authorization for medical information contained herein to be released to the Florida Department of Health, State and County emergency management agencies, 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 from the provisions of F.S. 119.07 (1), Public Records Law. The information contained here will be kept confidential.

Signature of Applicant: _____

Date: _____

Printed Name: _____

Receiving Agency: _____

Date: _____

Received By: _____

Florida, Region III Special Needs Shelter (SpNS) Go Kit Checklist for Clients

In an emergency evacuation, if you have a medical condition that requires basic medical assistance and monitoring, but does not require hospitalization, a Special Needs Shelter may be appropriate for you. Preregistration is important and encouraged, to ensure that you are ready for evacuation and sheltering in the event of an emergency in your county. Family members and caregivers are encouraged to accompany you. Use this checklist to help you prepare a Special Needs Shelter Go Kit that will make your stay as comfortable as possible.

PLEASE KEEP THIS CHECKLIST WITH YOUR IMPORTANT PAPERS.

MEDICAL SUPPLIES AND EQUIPMENT TO BRING (IF NEEDED)

PACK A FIVE-DAY SUPPLY OF ALL CONSUMABLE ITEMS

- Batteries and or chargers for electrical equipment such as a wheel chair, scooter, etc.
- Cane, folding cane or walker
- Catheter Supplies
- Diabetes equipment
 - Glucose meter/strips/lances
 - Insulin and Syringes
 - Other insulin supplies
 - Sharps container (should be one at SpNS)
- Documentation of specific medical information (including provider contact information)
- First-Aid Kit
- List of current medications and at least a 120-hour (five day) supply of them (recommend seven days)
- Nebulizer if needed with operating supplies
- Ostomy supplies for your needs
- Oxygen supplies for your needs
- Repair kit for your electrical equipment
- Wound care supplies
- Any other specialized medical item you may need

FOOD ITEMS

- Non-Perishable dietary items
- Snacks or other comfort foods (general meals are normally provided at the shelter)
- Special dietary foods, if you require them

Entertainment Items and Personal Specialty Equipment

- Cell phone with charger
- Reading material, books, games, and magazines etc.
- Radio
- Portable (small) video player with videos
- Flashlight
- Extra batteries
- Dentures
- Extra pair of glasses or dark glasses if medically required
- Hearing aids with extra batteries
- Pair of gloves to use in case of emergency
- Rain Gear
 - For caregiver or family member(s)

- Air mattress or cot and bedding

- Portable lawn or lounge chair

- For Special needs client

- Cot or air mattress if cot is not provided

- Bedding (sheets, blanket, and pillow)

PERSONAL ITEMS

- Body wipes and/or washcloth, and towel(s)
- Brush or comb and Deodorant
- ID with current address
- Important papers, pictures, contacts, and a small amount of cash
- Incontinence supplies
- Shoes (especially specialty ones)
- Soap and shampoo or shaving supplies
- Toothbrush with toothpaste (mouthwash if needed)
- Undergarments and socks

- Extra clothing items
- Advanced legal directives: Will, DNR, Power of Att.

INFANT CARE

- Baby wipes
- Diapers
- Formula/food
- Blankets, sleeping items
- Medication if infant is prescribed any
- Toys, things to entertain child

SERVICE ANIMAL SUPPLIES

- Food, dishes, and medicines
- Plastic bags, disposable gloves and other body functional needs
- Toys for the animal (if needed)

ITEMS NOT NORMALLY ALLOWED IN THE SpNS

- Pets (except for service animals: dog or miniature horse). Proof of vaccinations may be required.
- Firearms or weapons
- Alcoholic beverages or illegal drugs
- Perishable food items

NOTE: Check with your local Emergency Operations Center or local Department of Health for additional information concerning Special Needs Sheltering and pre-registration.

(5/2/2017)