

PINELLAS COUNTY EVACUATION ASSISTANCE /SPECIAL NEEDS REGISTRATION

Registration for: Special Needs Shelter Transport Assistance Both

LAST: _____ FIRST: _____ DOB: ____ / ____ / ____ SEX: _____

STREET#: _____ 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: _____

CARE TAKER _____ HOSPICE, TEAM ID ____ HOME HEALTH: _____

DO YOU HAVE A PET? Arrangements for pet completed - Call 582-2600 for assistance details

SPECIAL NEED (CHECK ALL THAT APPLY) Questions? Call Health Dept - 820-4155

<input type="checkbox"/> Kidney disease Dialysis where _____ <input type="checkbox"/> Diabetes/insulin depend <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart disease <input type="checkbox"/> Dialysis <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer	<input type="checkbox"/> Emphysema <input type="checkbox"/> Memory impaired <input type="checkbox"/> Mental health impaired <input type="checkbox"/> Sight impaired <input type="checkbox"/> Service dog <input type="checkbox"/> Speech impaired <input type="checkbox"/> Hearing impaired <input type="checkbox"/> Breathing treatment	<input type="checkbox"/> Walker/cane <input type="checkbox"/> Wheelchair user <input type="checkbox"/> Bedridden <input type="checkbox"/> Incontinence <input type="checkbox"/> Oxygen (lpm _____) <input type="checkbox"/> Geri chair	<input type="checkbox"/> Feeding tube <input type="checkbox"/> Ventilator <input type="checkbox"/> Electric dependent, Why? _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> None
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Emergency Contacts

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

Prearranged: Hospital Nursing Home ALF

Name: _____ Phone: _____

Doctor's name: _____ 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 Stretcher Ambulance

Fire Dist: _____ Grid: _____ Evac Level: _____ Shelter Code: _____ 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 9/09