



**SPECIAL NEEDS SHELTER
EVACUATION
REGISTRATION FORM**

Today's Date: _____

PATIENT INFORMATION:

Name: _____
Last First Middle

Street Address: _____

City: _____ Zip Code: _____

Telephone: _____ / _____
Area Code Number Alternate Number (cell phone, etc.)

Social Security Number: _____ Date of Birth: _____

Age: _____ Sex: Male _____ Female _____

Primary Language: _____ Secondary Language: _____

Living Situation: Live Alone _____ With Spouse: _____ With Parents _____
With Parents _____ With Child (ren) _____ Other _____

Who has agreed to be your caregiver at the special needs shelter?

Name: _____ Phone with area code: _____

EMERGENCY CONTACT:

(Local) Name: _____ Phone: _____

(Non-local): Name: _____ Phone: _____

ASSISTANCE REQUIRED:

Do you intend to evacuate in an emergency? _____ Do you need transportation to a shelter? _____ Do you need a bus, car, wheelchair van, or ambulance? _____
(circle one)

Note: Only you and one caregiver will be given transportation.

DIAGNOSES: _____

MEDICAL CARE INFORMATION:

(Please Mark Only Those That Apply)

(YOU MUST BRING ALL YOUR OWN MEDICATIONS, EQUIPMENT AND MEDICAL SUPPLIES WITH YOU)

Respirator Dependent _____ **Dialysis Dependent** _____ **Sight Impaired** _____

Blind _____ **Uncorrected Vision** _____ **Sign** _____

Speech Impaired _____ **Hearing Impaired** _____ **Mobility Impaired** _____

IV Therapy _____ **Foley Catheter** _____

Mental Health Impaired _____

Ostomy Care _____ **Oxygen Dependent** _____ **Nebulizer Therapy** _____

Diabetic _____/oral _____ **insulin** _____ **Nebulizer Therapy** _____

Wheelchair Bound _____ **Bed Bound** _____ **Walker** _____ **Cane** _____

Medical Dependence on Electricity _____ **Special Dietary Needs** _____

Allergies _____

Tracheotomy _____ (date preformed) _____ **Suction Required** _____

Cardiac History _____ (date(s)) _____ **Amputee** _____ (date) _____

Dressings _____ **Simple non-sterile** _____ **Complex sterile** _____

Memory Impaired _____ **Senile** _____ **Alzheimer** _____ (caregiver required)

Incontinence _____ **Bowel** _____ **Bladder** _____

Tube Feedings _____ (bring 4 days supply)

Hospice Care _____

