

PINELLAS COUNTY EVACUATION ASSISTANCE /SPECIAL NEEDS REGISTRATION

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

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

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: _____