

Special Needs Shelter Application

DeSoto County Emergency Management

115 East Oak Street B-1

Arcadia, FL 34266

Phone (863)993-4831 Fax (863) 993-4840

INSTRUCTIONS: This form was created to aid in providing assistance to those citizens of this county who have a special need during a declared state of emergency. If you are a citizen with a special need and are a client of a local health agency, you may wish to coordinate the completion of this form with your assigned professional.

INFORMATION

Last name:	First:	Middle:
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Street address:	Lot / Apt No:	Home phone no.: ()
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P.O. box:	City:	State:	ZIP Code:
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Are you a seasonal resident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, months residing in DeSoto County:	Is this a mobile home? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Who will stay with you at the shelter/Who is your caregiver? Address:	Phone:
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Emergency Contact (Not Living With You): Address:	Phone:
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PHYSICIAN / PROVIDER INFORMATION

Physician name:	Phone:
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Home Health Agency:	Phone:
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Other agencies: (Hospice – Dialysis - Oxygen)	Phone:
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TRANSPORTATION / MOBILITY INFORMATION

TRANSPORTATION

If in an emergency situation you were instructed to leave your home and move to a emergency shelter, how would you get there?

- Your own car
- Neighbor
- Do not have a way

MOBILITY

- Ambulatory
- Wheelchair
- Bedridden
- Walker
- Cane

TRANSPORTATION NEEDS

- Ambulance
- Van with a wheelchair lift
- Walker Assistance
- Regular car or van
- Other: _____

MEDICAL INFORMATION

MEDICAL INFORMATION

Check all disabilities that you may have:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Arthritis, Severe | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Diabetes ___oral ___insulin | <input type="checkbox"/> Complete Paralysis |
| <input type="checkbox"/> Partial Paralysis | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Memory Impairment | <input type="checkbox"/> Blind (Service dog Y N) |
| <input type="checkbox"/> Ostomy | <input type="checkbox"/> Any Open Wounds | <input type="checkbox"/> Any Tuberculosis | <input type="checkbox"/> Hearing Impaired |
| <input type="checkbox"/> Back Injury | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Anxiety / Nerves | <input type="checkbox"/> Do you have TTD? |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Any Hepatitis | | |
| <input type="checkbox"/> Breathing Impaired | <input type="checkbox"/> Oxygen ___#hrs used ___L/min ___ Tank ___ O2 converter (bring concentrators to the shelter) | | |

Other medical conditions: _____

(over)

AUTHORIZATION FOR SEARCH AND RESCUE

I, _____, authorize emergency response personnel to enter my home address at _____ during search and rescue operations if necessary to insure my safety welfare following a declared state of emergency.

SIGNATURE: _____ DATE: ____/____/____

PET INFORMATION

**ONLY SERVICE ANIMALS WILL BE PERMITTED IN THE SHELTER
PLEASE MAKE ARRANGEMENTS FOR YOUR PET IF YOU HAVE TO EVACUATE.**

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, GIVE MY AUTHORIZATION FOR THE MEDICAL INFORMATION CONTAINED HEREIN TO BE RELEASED TO THE COUNTY HEALTH DEPARTMENT. I UNDERSTAND THAT THIS INFORMATION WILL BE USED SOLEY FOR THE PURPOSE OF EVAULATING MY NEEDS IN A TIME OF DELCLARED STATE OF EMERGENCY AND WILL BE MAINTAINED AS CONFIDENTIAL. I PROVIDE THIS INFORMATION ON A VOLUNTEER BASIS.

SIGNATURE: _____ DATE: ____/____/____

ITEMS TO BRING TO THE SPECIAL NEEDS SHELTER

- | | |
|---|-------------------------------|
| ♀ A list of your current medications and at least a 3 day supply of the medications | ♀ Important papers |
| ♀ Documentation of specific medical information | ♀ I.D. with current address |
| ♀ Medical equipment | ♀ Entertainment items |
| ❖ Oxygen supplies | ❖ Books |
| ❖ Nebulizers | ❖ Magazines |
| ❖ Canes/Wheelchairs | ❖ Toys |
| ❖ Diabetes equipment | ❖ Cards |
| ◆ Glucose meter/strips | ❖ Games |
| ◆ Insulin/syringes | ♀ Infant care items |
| ◆ Other insulin supplies | ❖ Formula |
| ♀ Non-perishable dietary items | ❖ Food |
| ❖ Special dietary foods if required | ❖ Diapers |
| ♀ Electronic equipment | ♀ First-aid kit |
| ❖ Flashlight | ♀ Personal equipment |
| ❖ Radio | ❖ Eyeglasses |
| ❖ Extra batteries | ❖ Hearing aids |
| ❖ Cell phone | ❖ Dentures |
| ♀ Personal Care | ♀ Sleeping lounging equipment |
| ❖ Clothing | ❖ Pillow |
| ◆ Undergarments | ❖ Blanket |
| ◆ Socks | ❖ Sheet |
| ◆ Shoes (durable) | |
| ♀ Personal hygiene items | DON'T Bring |
| ◆ Soap/shampoo | ♀ Pets |
| ◆ Deodorant | ♀ Firearms |
| ◆ Toothpaste/toothbrush | ♀ Alcoholic Beverages |
| ◆ Brush/comb | ♀ Perishable Food Item |
| ◆ Wash cloth | |
| ◆ Towel | |