Lake County Office of Emergency Management

Special Needs Registry Form

Date: ______________

Florida and Federal law require that information contained in your medical records be held in strict confidence without your written consent. The consent you sign on this page will remain in effect until you request in writing that your consent be withdrawn, which you may do at any time. You have a right to request and obtain a copy of this consent. This form is intended for Special Needs Registration purposes only. Dissemination, distribution, or copying of this form is strictly prohibited except for use by authorized persons. The original of this form shall be secured in a locked file.

PERSONAL INFORMATION

Last Name: ___________________ First Name: ___________________ MI: __ DOB: ___________________

Gender: ☐ M ☐ F Last Four of Social Security #: _______

Street Address: ____________________________ City, St.: ________________ Zip Code: ______________

☐ Same as Above

Mailing Address: ___________________________ City, St.: ________________ Zip Code: ______________

Home Phone: ________________________ Cell: __________________________ Primary: ☐ Home ☐ Cell

Email Address: _______________________________

In City Limits: ☐ Yes ☐ No Mobile Home: ☐ Yes ☐ No Flood Prone: ☐ Yes ☐ No

Living Situation: ☐ Lives Alone ☐ With Spouse ☐ With Children ☐ With Parents ☐ Significant Other

MEDICAL INFORMATION *Check and complete those that apply to your medical condition.*

Electric Dependent Medical Equipment:

☐ Oxygen
- ☐ Continuous
- ☐ PRN
- Amount: ______

☐ Nebulizer
- How Often: _______

☐ Ventilator ☐ Suction
☐ Feeding Pump ☐ IV Therapy Pump
☐ Wound Vac ☐ Dialysis

Home Health Agency: ___________________

Medical Equipment Supply Co.: ___________________________

Other Agency Affiliation: _____________________________

Do you use any mobility assist devices?
☐ Walker ☐ Wheel Chair
☐ Cane ☐ Motorized Scooter

Are you Incontinent?
☐ Yes ☐ No

Do you have any sensory impairments? ☐ Vision ☐ Hearing ☐ Speech

☐ Flight Risk | ☐ Fall Risk | ☐ Memory Impaired | ☐ Weight >300Lbs | ☐ Bedridden | ☐ DNR (Attach Copy)

Significant Past Medical History:

____

Allergies and/or Special Dietary Needs:

____

Medications (Include dosage and frequency, Attach extra sheet if needed):

____

____

Primary Diagnosis: ____________________________________

Secondary Diagnosis: ____________________________________

Emergency Management Use Only	Health Department Use Only
Client ID: Initials:	☐ SN 1 (Shelter) ☐ SN 2 (Hospital) ☐ SN 3 (RO) Initials:

EMERGENCY CONTACT INFORMATION

PRIMARY
Name: _________________________ Relationship: ________________ Phone: _________________

SECONDARY
Name: _________________________ Relationship: ________________ Phone: _________________

Will someone accompany you to the shelter?
Name: _________________________ Relationship: ________________ Phone: _________________

PHYSICIAN/ PHARMACY INFORMATION

Physician:
Last Name: _____________________ First Name: _________________ Phone: _________________

Pharmacy Name: ___________________________ Phone: __________________________

TRANSPORTATION

Will you provide your own transportation to the shelter? ☐ Yes ☐ No (If no, please continue to next question)

If you need assistance with transportation, check one of the types of transportation you need:
☐ Automobile ☐ Van with Wheelchair Lift ☐ Stretcher

PET INFORMATION

If pets will be accompanying you to the shelter, check the appropriate box and indicate how many.
☐ Dog ____ ☐ Service Animal ☐ Cat _____ ☐ Other (Explain) ________________

ADDITIONAL COMMENTS

PREAUTHORIZATION TO ENTER HOME BY EMERGENCY PERSONNEL

I authorize emergency response personnel to enter my home during search and rescue operations following a disaster, if necessary, to assure my safety and welfare. *Preauthorization to enter your home by emergency personnel is optional.*
Authorized Signature: _______________________________ Date: ______________

AUTHORIZATION *This document must be signed, or it will be considered void*

I, (Print Name) __________________________ understand that all my medical record are confidential, exempt from the public records law, and not to be disclosed to anyone without my consent or that of my guardian pursuant to section 455.241, Florida Statues.

I hereby provide my consent for the member of Lake County Office of Emergency Management Office to have access to the medical information contained in this form.

I understand that this form is not a reservation for Special Needs Shelter, but my medical information will be utilized to determine/ assess plans appropriate for my care and treatment during an emergency.

I further understand that only those persons who need to know this information will have access to it. This release remains in effect until further notice unless revoked by me in writing.

Authorized Signature: ___________________________________ Date: _________________

Print name of person completing this form if other than client: ___________________________

Mail Form To | Lake County Emergency Management | PO Box 7800, Tavares, FL 32778 | 352.343.9420