Union County Sheriff's Office, Office of Emergency Management

Date	SPECIAL NEEDS REGISTRY FORM	Patient ID

Florida and Federal law requires that information contained in your medical records be held in strict confidence and not be released without your written consent. The consent you sign on this page will remain in effect until you request that your consent be withdrawn, which you may do at any time.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.

Home Health Agency	Medical Equipment/Oxygen Supply Co.	Dialysis Center

Other Agency Affiliations (i.e., Hearing, Visual, Developmental, Mental Health Services; Other Special Services)

PERSONAL INFORMATION

Last Name	First Name	MI	Language Spoken	Date of Birth	Sex
					☐ M ☐ F

Street Address	City	Zip	Phone

Mailing Address (if different)	City	Zip	Do You Live in a Mobile Home?
			☐ Yes ☐ No

Name of Subdivision, MH Park, Apt Bldg., etc.	If address is temporary, give dates	Flood Prone Area
	From: To:	☐ Yes ☐ No

Living Situation ☐ Lives Alone ☐ With Spouse ☐ With Children ☐ With Parents ☐ Other_____

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

☐ Required or Life-Sustaining Medical Equipment

☐ Oxygen Concentrator ☐ Respirator(Ventilator)
☐ Portable Oxygen ☐ Suction Machine
☐ Nebulizer ☐ Other _____

☐ Oxygen - CPAP/BIPAP # of LPM of _____

☐ Oxygen - PRN (As Needed) # of liters _____

☐ Electrical Dependent
☐ High Blood Pressure
☐ Cardiac History
☐ Dialysis How Often? _____
☐ Incontinent
☐ Life-Sustaining Medications
☐ Frail
☐ Seizures/Convulsions
☐ Mobility Impaired
☐ Insulin Dependent
☐ Breathing Problems
☐ Wheelchair Bound

☐ Bedridden
☐ Confined to a bed 24 hours day
☐ Can you transfer to your wheelchair for transport?
☐ Weight > 300 lbs.
☐ Hearing Impaired
☐ Sight Impaired
☐ Contagious Disease
☐ Speech Impaired
☐ Memory Impaired
☐ Anxiety/Depression
☐ Emergency Alert Equipment
☐ DNR Order (if so, attach copy)
☐ Stroke Patient
☐ Daily Medication
☐ Mental Health Impaired (Explain)

☐ Special Dietary Needs (Explain)

☐ Allergies (List) _____

☐ List Special Equipment Needed (Explain)

Print Name of Person Completing This Form Below:

Contact Number:

EMERGENCY CONTACT INFORMATION:

First Name:	Last Name:	Relationship:	Phone:
First Name:	Last Name:	Relationship:	Phone:

PHYSICIAN/PHARMACY INFORMATION:

Physician's Last Name:	First Name:	Phone:
Pharmacy Name:		Phone:

SHELTER INFORMATION:

Will you provide your own transportation to the shelter? □ Yes □ No

If you need assistance with transportation, check one of the types of transportation you need:

- □ automobile
- □ van w/wheelchair lift
- □ stretcher
- □ ambulance(patient must initial)_____

(Note: If ambulance is requested, patient will be responsible for transportation costs by ambulance.

Name of person going with patient to the shelter:

PET INFORMATION:

(If applicable, indicate how many)
Pets Are Not Allowed In Shelters

□ Cat _____ □ Large □ Small

□ Dog _____ □ Large □ Small

□ Guide Dog _____

□ Other (Explain)_____

Phone:

COMMENTS:

AUTHORIZATION INFORMATION:

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.

Authorized Signature:

I, (Print Name)

understand that all of my medical records 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 Statutes.

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

I understand that this form is not a reservation for the Special Needs Shelter but that 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 have a 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:

Mail form to: Union County Sheriff's Office, Office of Emergency Management, 58 NW 1st Street, Lake Butler, Fl. 32054
(386) 496-4300