

Osceola County's Office of Emergency Management

SPECIAL NEEDS PROGRAM REGISTRATION FORM

(This form must be filled out completely. Please print clearly)

Completed by Client <input type="checkbox"/> Caregiver <input type="checkbox"/> Agency <input type="checkbox"/>			
(For Agencies)		Agency Name _____	Agency Phone _____
Last Name:	First Name:	Birth Date: ____/____/____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F Primary Language: _____
Address:		Apartment/Unit#:	
City:	Zip:	Name of Complex/Subdivision:	
Type of Residence: <input type="checkbox"/> Single Family Home <input type="checkbox"/> Apartment/Condo <input type="checkbox"/> Mobile Home/Manufactured Home			
Home Phone: _____ Mobile Phone: _____ Other Phone: _____			
E-Mail Address: _____			
EMERGENCY INFORMATION			
Living Status: <input type="checkbox"/> Alone <input type="checkbox"/> With Relative <input type="checkbox"/> With Caregiver <input type="checkbox"/> Other (please indicate) _____			
Local Emergency Contact Name:		Local Emergency Contact Phone:	
Non-Local Emergency Contact Name:		Non-Local Emergency Contact Phone:	
Will you have a companion/caretaker accompanying you to the evacuation location? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, Companion Name: _____ Companion Phone: _____			
CLIENT INFORMATION			
Do you use oxygen?		<input type="checkbox"/> Yes (<input type="checkbox"/> Intermittent <input type="checkbox"/> Continuous) <input type="checkbox"/> No	
• If yes, Oxygen Provider: _____ Phone: _____			
Do you use medical equipment that requires electricity to operate?		<input type="checkbox"/> Yes (<input type="checkbox"/> Intermittent <input type="checkbox"/> Continuous) <input type="checkbox"/> No	
• If yes, specify the equipment that requires electricity:			
Require a Ventilator		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Alzheimer/Dementia		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hearing Impaired		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Visually Impaired		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you receive dialysis?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you confined to a bed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you require a Hoyer lift to transfer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you utilize a service animal?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have pets?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use a wheelchair?		<input type="checkbox"/> Yes (<input type="checkbox"/> Electric <input type="checkbox"/> Manual) <input type="checkbox"/> No	
Do you require transportation to a shelter?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
• If yes, do you require ADA / Wheelchair Lift?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
OFFICE USE ONLY			
Date:	Reviewer:	SN Shelter: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Beyond Care: (Reason for alternate care)			