Hendry County Emergency Management
Special Needs Registration

This program is designed for those who have special physical and/or medical needs and may require government evacuation and/or shelter assistance in the event of an emergency. Please complete this registration and mail it to the address listed on the back bottom section of this form. This information is requested pursuant to Section 252.355, Florida Statutes, which also mandates that all information contained within is confidential and exempt from disclosure and can be made available only to other emergency response agencies. The review process may take up to two (2) weeks before you are notified if you have been accepted.

Personal Enrollment Data: **TODAYS DATE: _____**

NAME: _____ PHYSICAL ADDRESS:_____

MAILING ADDRESS:_____CITY: _____ ZIP CODE: _____

TELEPHONE: _____D.O.B: ___/_____/____Height: _____Weight:_____Gender: M or F

Primary 1st Language: English or Spanish

Caregivers Name: Who will stay with you at the shelter? _____

Caregiver Address: _____ Caregiver Phone Number: _____

(Circle) Residence Type: ⇨House / Duplex ⇨Mobile Home ⇨ Apartment / Condominium

(Circle) Living Situation: ⇨Living alone ⇨With Spouse ⇨ With Spouse & Children

⇨With Children ⇨With Parent(s) ⇨With Other Relative ⇨With Non-Relative

Best time and phone number for reviewer to call you: _____

Emergency Contacts:

Name: _____ Relationship: _____ Phone: _____
(Local)
Name: _____ Relationship: _____ Phone: _____
(Non-local)
Person Completing Form (If different than above) _____

Home Health/Assisting Agency: _____Phone #:_____

Primary Doctor: _____Phone#:_____

Pharmacy Name: _____Phone#: _____

Medical Care Information:

Medical Problems: _____

_____

Medications: _____

_____

Allergies: _____

Special Medical Needs (Circle all that apply)

⇨ Medical Dependence on Electricity	⇨ Memory Impaired	⇨Anxiety/Depression
⇨ Mental Health Impaired	⇨ Respirator Dependent	⇨ Dialysis Dependent
⇨ Insulin Dependent	⇨ Speech Impaired	⇨ Emergency Alert Monitors
⇨ Walker/Cane	⇨ Bedridden	⇨ Mobility Impaired
⇨ Wheelchair Bound	⇨ Incontinence	⇨ Seizure
⇨ Special Dietary Needs	⇨ Sight Impaired	⇨ Hearing Impaired
⇨ Oxygen Dependent	⇨ Ostomy	⇨ Pacemaker
⇨ Cardiac History	⇨Large Open Wounds	⇨ Arthritis/Osteoporosis
⇨Cardiac Apparatus	⇨Alzheimer's/ Dementia	⇨ Pregnancy (1st, 2nd, 3rd Trimester)
⇨Autism	⇨OCD	⇨ Conduct Disorders
⇨Trained Service Animal_____	⇨Other **(Specify)** _____	

Assistance Required:

Do you need transportation to the shelter? : ⇨ YES ⇨ NO

(Circle) All That Apply: ⇨ Ambulatory ⇨ Wheelchair ⇨ Stretcher ⇨Medication

Do you have a current? **⇨ Living Will** **⇨ DNR (Do Not Resuscitate)** **⇨ Designated Health Care Surrogate**

Please attach a current copy with your registration.

MAIL Registration To: Hendry County Emergency Management
P. O. Box 2340
LaBelle, Florida 33975

THIS SECTION TO BE COMPLETED BY EMERGENCY MANAGEMENT

Priority Code: ⇨ High ⇨ Medium ⇨ Low ⇨ None

⇨ Staying @ Home With Relatives, Friends, Other

⇨ Public Shelter- Needs Can Be Met In Non-Medical Facility

⇨ West Glades Schools "Special Needs Shelter"

⇨LaBelle N.H. ⇨Clewiston N.H. ⇨HRMC

Review Date: _____