

# MARION COUNTY EMERGENCY MANAGEMENT SPECIAL NEEDS FORM

<b>PERSONAL INFORMATION: (Print Legibly)</b>				
Last Name:	First Name:	MI.	Birth date	Sex: _____ Weight: _____ Height: _____
Street Address:	City:	State:	Zip:	Phone:
Mailing Address (If different):	City:	State:	Zip:	Phone:
Name of Subdivision, MH Park, Apt Bldg., etc.:	Flood Prone Area? <input type="checkbox"/> Yes <input type="checkbox"/> No	Temporary Address: From: _____ To: _____		Primary Language Spoken:
Type of Structure (check one) <input type="checkbox"/> Mobile <input type="checkbox"/> Manufactured <input type="checkbox"/> Site Wood Built <input type="checkbox"/> Masonry <input type="checkbox"/> Other				
Living Situation: (check one) <input type="checkbox"/> Lives Alone <input type="checkbox"/> With Spouse <input type="checkbox"/> With Children <input type="checkbox"/> With Parents <input type="checkbox"/> Other (Explain)				

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

### Require Life-Sustaining Medical Equipment ? (Check those that apply)

*[You must bring your own equipment with you to the shelter.]*

- Suction Machine  Respirator (Ventilator)
- Positive Airway Pressure Equipment (CPAP)
- Nebulizer  Feeding Pump
- Other \_\_\_\_\_
- Oxygen – Type:  Liquid  Gas  Oxygen Concentrator
  - Continuous  As Needed  Occasional
- How Often \_\_\_\_\_ Rate \_\_\_\_\_ (liters/min)
- Amount used per day? \_\_\_\_\_
- How is it given? \_\_\_\_\_

### Check any of the following that apply to you

- Seizures (Explain) \_\_\_\_\_
- Colostomy or Ileostomy
- Stroke
- Cardiac History
- Dialysis How Often? \_\_\_\_\_
- Urine Control Problem  Bowel Control Problem  both
- Memory Impaired (Explain) \_\_\_\_\_
- Psychiatric/Personality Disorder
  - Anxiety/Depression
  - Alzheimers
  - Dementia
  - Autism
  - Obsessive Compulsive Disorder
  - Conduct Disorder
- Mental Health Impaired (Explain) \_\_\_\_\_
- Frail \_\_\_\_\_
- Mobility Impaired (Explain) \_\_\_\_\_

### Require equipment to help with mobility?

- Wheelchair Bound
- Walker
- Other \_\_\_\_\_
- Bedridden
  - Can you transfer to a wheel chair
- Sensory Impaired
  - Hearing
  - Sight
  - Speech
  - Other \_\_\_\_\_
- Equipment used to assist with impairment \_\_\_\_\_

### Other

- DNR Order (if so, attach copy)
- Special Dietary Needs (Explain) \_\_\_\_\_

### Medication

- Medication requiring refrigeration
- Assistance required with Medications

### List of all medications:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies (List) \_\_\_\_\_

\_\_\_\_\_

**List of all *other* medical conditions:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION: 1 Local and 1 Non-Local**

(Local) First Name	Last Name	Relationship	Phone
(Non-Local) First Name	Last Name	Relationship	Phone

**PHYSICIAN/PHARMACY INFORMATION:**

Physician's Last Name:	First Name:	Phone:
Pharmacy Name:	Phone:	
Home Health Care Agency/Nurse Registry:	Phone:	
Hospice:	Phone:	
Dialysis Center:	Phone:	
Medical Equipment Provider:	Phone:	

**SHELTER INFORMATION:**

Plan on using a shelter?  Yes  No  
Provide Own Transportation to Shelter:  Yes  No

If you need assistance with transportation, check one of the following:  
 automobile  
 van with wheelchair lift  
 stretcher

Name of person going with patient to the shelter:  
\_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**PET INFORMATION:**

Trained Service Animal (Only service animals are allowed in the shelters.)

**(Make arrangements for your pet with a vet, kennel, or bring your pet to our pet friendly shelter. Pets must have a caretaker stay with them at the pet friendly shelter.)**

Phone: \_\_\_\_\_

**AUTHORIZATION INFORMATION:**

I agree that my name be added to the Special Needs Emergency Shelter list. I give Marion County Emergency Management authorization to share this information with other local support agencies in the event of an emergency evacuation. I also grant emergency response personnel permission to enter my home during search and rescue operations following a disaster, if necessary, to assure my safety and welfare.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**EMERGENCY MANAGEMENT USE ONLY:**

Previous Application:  Yes  No  SN  Public Shelter  Stay Home  Dialysis Center

Need More Information \_\_\_\_\_

Approved: \_\_\_\_\_ Denied: \_\_\_\_\_ Reason: \_\_\_\_\_

Initials: \_\_\_\_\_

Mail Form to: Marion County Emergency Management, PO Box 1987, Ocala, FL 34478-1987 (352) 622-3205 *Revised 01/15/08*