MARTIN COUNTY EVACUATION ASSISTANCE/SPECIAL NEEDS REGISTRATION

CHOOSE ONE: Registration for: ☐Transport Assistance ☐Special Needs Shelter ☐Both

LAST: _____ FIRST: _____ MI: ____ Date of Birth: _____
Month/ day/ year

STREET ADDRESS: _____ APT#: _____ LOT#: _____

CITY: _____ ZIP: _____ PHONE: _____ CELL: _____

MAILING ADDRESS *IF DIFFERENT FROM ABOVE*: _____ CITY: _____ STATE: ____ ZIP: _____

☐SINGLE FAMILY/DUPLEX ☐MOBILE/MANUFACTURED ☐APT/CONDO ***COMPLEX NAME:** _____

❖**YOUR E-MAIL ADDRESS:** _____ ☐ **I COULD NEED ASSISTANCE BOARDING A BUS**

LIVING SITUATION: ☐ALONE ☐RELATIVE ☐OTHER **ARE YOU REGISTERED WITH THE COUNCIL ON AGING** ☐YES ☐NO

DO YOU HAVE A PET: ☐YES ☐NO ☐Arrangements for pet(s) are completed **ARE YOU A SEASONAL RESIDENT?** ☐YES ☐NO

❖***For Transportation Assistance to a public shelter, complete the section above and the remaining sections marked with this symbol*** ❖***in front.***

SPECIAL NEED CHECK LIST (CHECK ALL THAT APPLY) ***A Health Department representative will contact you with any questions***

☐ ***NONE***	☐ **Asthma**	☐ **Walker/Cane**	☐ **Open Wound Sores**
☐ **Kidney Disease**	☐ **Emphysema**	☐ **Wheelchair user**	☐**Contagious Condition, Why?**
☐ **Dialysis**	☐ **COPD**	☐ *Able to stand with help*	_____
☐ **Diabetes**	☐ **Breathing Treatment**	☐ *Unable to stand*	☐ **Allergies:** _____
☐ *Insulin Dependent*	☐ **Oxygen: _____ LPM**	☐ *Type of Wheelchair used:*	_____
☐ *Oral Medication (pills)*	☐ **Ventilator**	_____	☐**Electric Dependent, Why?**
☐ **High Blood Pressure**	☐ **Mental Health Impaired**	☐ **Bedridden only****	:_____
☐ **Heart Disease** Explain	Explain	☐ **Partial Paralysis** *Explain*	_____
:_____	:_____	:_____	☐ **Other Issues:**
_____	☐ **Acute Memory Loss***	☐ **Amputee** *Explain*	_____
☐ **Stroke**	*Caregiver Required*	:_____	_____
☐ *No problems*	☐ **Sight Impaired**-Explain	☐ **Feeding Tube** *Explain*	_____
☐ *Needs assistance*	:_____	:_____	_____
☐ **Cancer:**	☐ **Service Dog**	☐ **Medication administration**	☐Male ☐Female
☐ *On Chemotherapy now*	☐ **Speech Impaired**-Explain	**assistance** -Explain	**Height:** _____
☐ *On Radiation now*	:_____	:_____	**Weight:** _____
☐ **Incontinence**	☐ **Hearing Impaired**-Explain	_____	
	:_____		

☐***CAREGIVER**-WHO WILL ACCOMPANY YOU (only one): _____ PHONE: _____

☐ **HOME HEALTH AGENCY**: _____ **HOME HEALTH PHONE NUMBER**: _____

DOCTOR'S NAME: _____ **DOCTOR'S PHONE**: _____

☐ ****Prearranged with Hospital /Nursing Home/ ALF/ OTHER: (*Location and phone number*)_____

❖**IS ENGLISH YOUR PRIMARY LANGUAGE** ☐YES ☐NO: _____ ❖**TOTAL # OF PEOPLE IN YOUR GROUP FOR TRANSPORTATION**: _____

❖***EMERGENCY CONTACT EC (SOMEONE NOT LIVING WITH YOU)***

❖***EC* NAME**: _____ *EC* RELATIONSHIP: _____ *EC* PHONE: _____

By submitting this form I give my authorization for rescuers to enter my home during an emergency if necessary and the Martin County Special Needs Registry to release this information to other emergency response personnel, human service agencies, officials or those they deem necessary. Records relating to registration of disabled citizens are exempt as listed in the provisions of F.S. 119.07(1), Public Records Law. The information contained here will be kept confidential. I also understand that assistance will only be provided for the duration of the emergency and that alternative arrangements should be made in advance if I cannot return to my home. Should I require hospital or assisted living care I understand I must make arrangements myself.

** _____ RELATIONSHIP: _____ _____

❖***Name of person filling out form*** **** if not registrant*** **Date**

Official use only: **Review EMA:** _____ **Review MCHD -if required:** _____ **Review Other:** _____

☐ **Review** Notes: _____

Transport to: ☐General Shelter ☐Special Needs Shelter **Type of Transport:** ☐ Van/Bus ☐ Wheelchair lift transport ☐ Own vehicle ☐ Ambulance

Self Transport: ☐Register for Special Needs Shelter Only **Station**: _____ **Grid(s)**: _____ **Map Book Page(s)**: _____ **EPZ:** _____

Completed form can be mailed to: Martin County Emergency Management Agency, Voluntary Registration Program, 800 SE Monterey Road, Stuart, FL 34994, faxed to 772-286-7626 or emailed to ema@martin.fl.us

For more program information go to the Emergency Information link at www.martin.fl.us or call 772-287-1652 Ext #1 Rev 08/2014cad