

# LAKE COUNTY DEPARTMENT OF PUBLIC SAFETY/EMERGENCY MANAGEMENT DIVISION

Date	<b>SPECIAL NEEDS REGISTRY FORM</b>	Client ID
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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 The consent you sign on this page will remain in effect until you request in writing that your consent be withdrawn, which you may do at any time.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 Supply Co.	Dialysis Center
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Other Agency Affiliations (i.e., Children's Medical Services; Hearing, Visual, Developmental, Mental Health Services; Other Special Services)

## PERSONAL INFORMATION

Last Name	First Name	MI	Last 4 of Social Security # _ _ _ _	Birthdate (Mo/Day/Yr) _ _ / _ _ / _ _ _ _	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Ethnic Group <input type="checkbox"/> African/American (B) <input type="checkbox"/> Caucasian (W) <input type="checkbox"/> Hispanic (H) <input type="checkbox"/> Asian or Pacific Islander (AS) <input type="checkbox"/> American Indian or Alaskan Native (AI/AN)	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander (NH/PI) <input type="checkbox"/> Black & White (B&W) <input type="checkbox"/> American Indian or Alaskan Native & White (AI/AN&W) <input type="checkbox"/> American Indian or Alaskan Native & Black (AI/AN&B) <input type="checkbox"/> Asian or Pacific Islander and White (AS&W) <input type="checkbox"/> 2+Races Non-Hispanic (2+NH)
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Street Address	City	Zip	In City Limit <input type="checkbox"/> Yes <input type="checkbox"/> No
			Mobile Home <input type="checkbox"/> Yes <input type="checkbox"/> No
Mailing Address (if different)	City	Zip	Flood Prone <input type="checkbox"/> Yes <input type="checkbox"/> No
			Phone #s (Include Area Code)
Name of Subdivision, MH Park, Apt Bldg., etc.	If address is temporary, give dates: From:                      To:		Home: _ _ - _ - _ - _ Cell:    _ - - _ - - _ - -

Email Address: \_\_\_\_\_

Living Situation  Lives Alone  With Spouse  With Children  With Parents  Other \_\_\_\_\_

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

<input type="checkbox"/> Required or Life-Sustaining Medical Equipment <input type="checkbox"/> Oxygen Concentrator <input type="checkbox"/> Respirator(Ventilator) <input type="checkbox"/> Portable Oxygen <input type="checkbox"/> Suction Machine <input type="checkbox"/> Nebulizer <input type="checkbox"/> Other _____ <input type="checkbox"/> Oxygen - Continuous                      Amount of Oxygen? _____ <input type="checkbox"/> Oxygen - Treatments Only Amount of Oxygen? _____ How Often? _____ <input type="checkbox"/> Oxygen - PRN (As Needed) Nighttime-# of hours? _____ Daytime-# of hours? _____ Amount used per day? _____ <input type="checkbox"/> Cardiac History <input type="checkbox"/> Dialysis                      How Often? _____ <input type="checkbox"/> Incontinent <input type="checkbox"/> Life-Sustaining Medications (if checked, attach list) <input type="checkbox"/> Frail <input type="checkbox"/> Mobility Impaired (Explain) _____ <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Cane	<input type="checkbox"/> Wheelchair Bound <input type="checkbox"/> Bedridden <input type="checkbox"/> Weight > 300 lbs. <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Sight Impaired <input type="checkbox"/> Speech Impaired <input type="checkbox"/> Memory Impaired <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Emergency Alert Equipment <input type="checkbox"/> DNR Order (if checked, attach copy) <input type="checkbox"/> Mental Health Impaired (Explain) _____ <input type="checkbox"/> Special Dietary Needs (Explain) _____ <input type="checkbox"/> Allergies (List) _____ <input type="checkbox"/> Other (Explain) _____
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Primary Diagnosis:	Secondary Diagnosis:	If disability is temporary, give dates: From:                      To:
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<b>Emergency Management Use Only</b>	<b>Health Department Use Only</b>
Previous Application: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> SN Cat 1(SN Shelter) <input type="checkbox"/> SN Cat 2(Hospital) <input type="checkbox"/> SN Cat 3(Registry Only)
If yes, current status:	<input type="checkbox"/> Need More Information                      Initials: _____

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:		PET INFORMATION:	
Will you provide your own transportation to the shelter? <input type="checkbox"/> Yes <input type="checkbox"/> No If you need assistance with transportation, check one of the types of transportation you need: <input type="checkbox"/> automobile <input type="checkbox"/> van w/wheelchair lift <input type="checkbox"/> stretcher		If pets will be accompanying you to the shelter, check the appropriate box and indicate how many.  <input type="checkbox"/> Cat _____ <input type="checkbox"/> Dog _____ <input type="checkbox"/> Guide Dog _____ <input type="checkbox"/> Other (Explain) _____	
Name of person going with client to the shelter:			Phone:
COMMENTS:			
AUTHORIZATION INFORMATION:			
OPTIONAL: 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: <input type="text"/>			
I, (Print Name) <input type="text"/>			
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 Lake 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: <input type="text"/>			Date: <input type="text"/>
Print Name of Person Completing This Form If Other Than Client:			Phone:

Mail form to: Lake County Emergency Management, 425 W. Alfred St., PO Box 7800, Tavares, FL 32778-7800 (352) 343-9420