COUNTY (please check one):
☐ BAY ☐ CALHOUN
☐ FRANKLIN ☐ GULF
☐ HOLMES ☐ JACKSON
☐ WASHINGTON

PEOPLE WITH SPECIAL NEEDS REGISTRATION FORM

PLEASE PRINT

☐ INITIAL ☐ CHANGE

Last Name: _____ First Name: _____ MI: _____ Speak English? ___ Yes ___ No

Street Address: _____ DOB: ____/____/____ Age: ____ Sex: ____

City: _____ Zip Code: _____ Home Phone: _____ TDD/TDY: ☐ Y ☐ N SS#: ____-____-____

Next of Kin Name: _____ Home Phone: _____ Relationship: _____

Emergency Contact Name: _____ Home Phone: _____ Relationship: _____

Doctors Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

LIVING SITUATION: (Check All That Apply)	IMPAIRMENT: (Check All That Apply)	DISASTER PLAN:	DIRECTIONS TO HOME:
☐ Mobile Home/Trailer	☐ Mobility	☐ Staying at Home	FROM:
☐ Dependent on Electricity	☐ Memory	☐ To Any Shelter	
☐ Emergency Alert Equipment	☐ Vision	☐ To Special Needs Shelter	
☐ Life Sustaining Medications	☐ Hearing	☐ Needs Evacuation Transport By:	
☐ No Alternate Housing	☐ Wheelchair	☐ standard vehicle	
☐ No Emergency Heat	☐ Respirator Dependent	☐ ambulance ☐ lift gate	
☐ No Telephone	☐ Speech	☐ Other (family, hotel, hospital)	
☐ Lives Alone	☐ Mental	☐ Will Bring Caregiver to Shelter	
☐ Lives with Spouse	☐ Epilepsy	☐ Guide Dog	
☐ Lives with Spouse & Kids	☐ Anxiety/Depression	☐ Vial/Packet of Life User	
☐ Lives with Kids	☐ Cardiac History	☐ Other: _____	
☐ Lives with Parents	☐ Bedridden		
☐ Lives with Other Relative	☐ Insulin Dependent	**SPECIAL AREAS:**	
☐ Lives with Non-Relative	☐ Incontinent of Bowel/Bladder	☐ Lives in River Flood Zone	
☐ Lives in Group Home	☐ Special Diet: _____	☐ Lives in Hurricane Evac. Zone	
☐ Other: _____	☐ Oxygen Dependent	**OTHER CONCERNS:**	
_____	☐ Dialysis Dependent	☐ Patient has Pets: ☐ Dog ☐ Cat	
	☐ Other: _____	☐ Other Pets: _____	

I, the undersigned, give permission to release the information above to the Emergency Management Office for assistance with evacuation in the event of a Natural Disaster/Emergency. I also give Emergency Service Providers, whether paid or volunteer, permission to enter my home in case of emergency.

Patient Signature: _____ Date: _____ Witness: _____

Agency Name: _____ Phone: _____ Person Completing: _____

Additional Comments:

_____

_____

_____

_____

_____

Bay County EM; 644 Mulberry Ave.; Panama City, FL 32401 850-784-6167	Franklin County EM; 33 Commerce St.; Apalachicola, FL 32320 850-653-8977
Calhoun County EM; 20859 Central Ave. East, Room G – 40; Blountstown, FL 32424 850-674-8075	Gulf County EM; 1000 Cecil G. Costin, Sr. Blvd.; Port St. Joe, FL 32456 E-mail: gulf911@digitalexp.com 850-229-9111
Holmes County EM; 107 East Virginia Ave.; Bonifay, FL 32425 850-547-1112	Jackson County EM; 4447 Marian Street; Marianna, FL 32448 850-718-0008
Washington County EM; 1331 South Blvd.; Chipley, FL 32428 850-638-6203	

FOR USE BY AGENCY SUBMITTING ONLY: DELETION CODES (check one to remove from registration):
[ ] Moved [ ] Discharged [ ] Deceased [ ] No Longer Needs Assist

WHITE-EMA **YELLOW-CHANGE/REMOVE** **PINK-AGENCY**