

ST. LUCIE COUNTY SPECIAL NEEDS REGISTRATION

Last Name: _____ First Name: _____ Middle Name: _____

Street Address: _____ City: _____ Zip Code: _____

Home Phone # _____ Cell Phone #: _____ Sex ____ DOB: _____

Doctors Name: _____ Phone # _____ Office Address _____

Do you need TDD Notification? Y / N Winter Resident Only Y / N Religious Preference _____

Next of Kin: _____ Phone # _____ Is phone # same as registrant? Y/N

CARE GIVER ACCOMPANYING YOU TO SHELTER

Care Giver Name: _____ Care Giver Phone # _____

Address: _____ Care Giver Relationship: _____

Notes /Comments: _____

HEALTH INFORMATION

Disability Notes: _____

Medications: _____

Allergies to Medications/Other: _____

Pace Maker Y / N Model: _____ Oxygen? Y / N **Medically** depend on electricity? Y / N

Hospice Patient: Y / N Hospice Name _____

TRANSPORTATION
(PLEASE CHECK APPROPRIATE NEEDS)

___ I need transportation only, I have no way to get to a shelter.

___ I need transportation and medical attention.

___ I need medical attention only, I have transportation.

Do you use a wheelchair? Y / N Are you wheelchair bound? Y / N Are you bedridden?
Y / N Wheelchair ramp available? Y / N

Home Type: ___ Mobile Home ___ Manufactured Home ___ Condominium
___ Apartment

Name of Mobile Home/Manufactured Home Park or Apartment

**Please note: Medical shelters may not be air conditioned if emergency power is
required.**

PLEASE CONTINUE ON PAGE THREE OF THIS FORM

(FOR OFFICIAL USE ONLY)

South Shelter ___ North Shelter ___ Transportation Type ___ Medical Needs ___
Transp: ___

Zone: _____ Plant Evacuation Area: ___ Assigned Shelter Section ___
Bed# _____

Check In Date/Time: _____ Check Out Date/Time: _____

*******MEDICAL NEEDS CRITERIA*******

From criteria listed below, indicate with a check mark, one or more, that describes your medical need(s).

- Persons dependent upon a **health professional to administer injectable medications.**
- Persons requiring daily or more frequent dressing changes **by a health care professional.**
- Persons needing assistance **by a health care professional** with ostomy management, continuous peritoneal dialysis or indwelling catheters of any kind.
- Persons whose activities of daily living are so **restricted by immobility** that their basic medical needs must be met by others.
- Persons who require daily assessment of **unstable medical condition by Professional nursing personnel**, i.e., diabetes, cardiac, cystic fibrosis.
- Terminally ill patients who are in need of professional **assistance for administering** heavy doses of medication.
- Any resident whose **life depends upon electrically energized equipment** within his/her residence (i.e. suction machines, home dialysis machines, o2 concentrators) excluding electric wheelchair without other qualifying condition.
- Those who **depend** on oxygen therapy.
- Bedridden and require custodial care upon **advice of a personal physician.** (As per Florida Statutes – does not necessarily mean assigned to special needs medical facility. Other facilities such as a nursing home or hospital will be utilized.

*****IMPORTANT*****

If you have checked any of the medical needs criteria, please complete the following questions.

1. Do you currently have a home health nurse coming to your home: Yes / No.
2. If yes, name of agency that provides your special care_____
3. If no, who provides your special care now?_____
4. Specifically what type of care are you now receiving? Please be very specific.

PLEASE NOTE: MEDICAL SHELTERS MAY NOT BE AIR CONDITIONED IF EMERGENCY POWER IS REQUIRED.

Patient's Signature:_____ Date:_____

Person completing form_____ Date:_____
(If other than patient)

**Send Completed Form To:
St. Lucie County Public Safety
15305 Midway Rd.
Fort Pierce, Fl 34945
(772) 462-8100**

Essential Items You Must Bring To The Medical Shelter

- 1. Pillow, blanket and linens.**
- 2. Three day supply of non-perishable food for individual taste and/or special diet.**
- 3. Three day supply of drinking water in non-breakable container(s). (1 gallon per day, per person)**
- 4. Prescription medications in their prescription bottles.**
- 5. Medical supplies.**
- 6. Vital medical equipment i.e. oxygen concentrators, portable oxygen bottles.**
- 7. Personal Items:**
 - a. Important papers (Personal identification. Insurance policies).**
 - b. Reading Glasses.**
 - c. Personal hygiene articles (tooth brush, soap, towel, wash cloth)**
 - d. Change of clothing.**
 - e. Sweater or jacket.**
 - f. Rainwear.**
 - g. Flashlight with extra batteries.**
 - h. Quiet games i.e. cards, book, knitting.**