

SHELTER REGISTRATION

NAME (last, first) _____ PHONE _____

ADDRESS: _____ MOBILE HOME? _____

CITY/STATE/ZIP: _____

AGE: _____ SEX: _____ ZONE: _____

PHYSICIAN NAME: _____ PHONE _____

CARETAKER: _____ PHONE _____

NEXT OF KIN: _____ PHONE _____

ADDRESS: _____

MEDICAL DIAGNOSIS/CONDITION: _____

Check all of the following disabilities that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis, severe | <input type="checkbox"/> Back injury | <input type="checkbox"/> Partial Paralysis |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Breathing difficulty |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Complete Paralysis | <input type="checkbox"/> Oxygen support |
| <input type="checkbox"/> Blind | <input type="checkbox"/> Mental Illness, Specify _____ | |
| <input type="checkbox"/> Deaf/Hearing Impaired | <input type="checkbox"/> TDD Equipment (Y/N) | |

Can you walk unassisted? If not, do you require – wheelchair stretcher cane
Crutches walker other

If other, explain _____

EVACUATION PLAN

TRANSPORTATION

Do you have transportation to the shelter? _____

If not, what are your transportation needs?

- Ambulance _____
 Van with wheelchair lift _____
 Regular car or van _____
 Other (describe) _____

SHELTERING

Where do you plan to go?

- Special Needs Shelter _____
 Regular _____
 Hospital _____

Person who will accompany and provide care if evacuated, to special needs shelter:

Name _____ Phone _____.

By Signing below, I am authorizing emergency response personnel to enter my home during search and rescue operations, if necessary, to assure my safety and welfare followed a declared state of emergency.

DIRECTIONS TO YOUR HOME: _____

HOME HEALTH CARE AGENCY: _____ Date: _____

Consent for information to be released to Emergency Management for disaster preparedness purposes.

Signature _____ Date _____