# Florida Special Needs Registry – Personal Survey Form

## Your Personal Information

If your address does not reflect your actual physical location, then describe where the location is that emergency personnel can find you.

**First Name:**_____ **MI:**_____ **Last Name:**_____ **Suffix:**_____

**Email:** _____
*The email address will be utilized to provide annual reminders to update information.*

**Physical Address:**
Please enter the exact full street address ONLY in the space provided (e.g. 123 Anywhere Street). Please enter P.O. Boxes or R.R. #s on the ADDRESS 2 line.

**Address:**_____

**Apt #:** _____

**City:** _____ **State:**_____ **Zip Code:**_____

**County:**_____ **Municipality:** _____

**Mailing Address (Please enter if different than physical address):**

**Address:**_____

**Apt #:** _____ **P.O. Box:** _____

**City:**_____ **State:**_____ **Zip Code:**_____

**Primary Phone:**_____ **Ext.:** _____

Is Primary Phone TTY/TTD (Teletype Device): ☐ Yes ☐ No

**Secondary Phone:**_____ **Ext.:**_____

☐ I do not have a phone

**Date of Birth (MM/DD/YYYY):**_____

**Height:** (Feet)_____ (Inches)_____ **Weight:**_____

***Why do you need my height and weight?***

*It is important that emergency responders be aware of any condition you have that requires either special equipment or additional personnel to safely evacuate you. This includes gathering information on your size (both height and weight).*

**Gender** (Check one): ☐ Male ☐ Female **Eye Color:**_____

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## Emergency Contact Information

Please provide contact information for an individual with whom we can discuss your situation in the event that an emergency necessitates this. If you would rather not provide an emergency contact, please check:

☐ I choose not to provide emergency contact information.

**Primary Contact:**

**First Name:**_____ **MI:**_____ **Last Name:**_____ **Suffix:**_____

**Address:**_____

**Address:** _____

**City:** _____ **State:**_____ **Zip Code:**_____

Emergency contact's relationship to you (check one):

☐ None ☐ Friend ☐ Family Member ☐ Neighbor ☐ Caregiver ☐ Other

**Email:** _____

**Primary Phone:**_____ **Ext.:** _____

**Secondary Phone:**_____ **Ext.:**_____

☐ Checking this box allows medical information to be shared with this emergency contact.

**Secondary Contact (Please enter an out-of-area contact):**

**First Name:**_____ **MI:**_____ **Last Name:**_____ **Suffix:**_____

**Address:**_____

**Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

Emergency contact's relationship to you (check one):

☐ None ☐ Friend ☐ Family Member ☐ Neighbor ☐ Caregiver ☐ Other

**Email:** _____

**Primary Phone:**_____ **Ext.:** _____

**Secondary Phone:**_____ **Ext.:**_____

☐ Checking this box allows medical information to be shared with this emergency contact.

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**Additional Contact Information:**

**Physician Information:**

**Name:**_____ **Phone:** _____ Ext. _____

**Home Health Care Information:**

**Name:**_____ **Phone:** _____ Ext. _____

**Caregiver Information:**

**Name:**_____ **Phone:** _____ Ext. _____

**Pharmacy Information:**

**Name:**_____ **Phone:** _____ Ext. _____

**Home Medical Equipment Provider Information:**

**Name:**_____ **Phone:** _____ Ext. _____

**Dialysis Center Information:**

**Name:**_____ **Phone:** _____ Ext. _____

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## Evacuation Information

If there were an emergency requiring evacuation, you may have difficulty evacuating or being notified of the need for evacuation because of the following conditions (check all that apply):

- ☐ Blind/Low Vision
- ☐ Deaf/Hard of Hearing
- ☐ Behavioral Health Issues
- ☐ Contagious Disease
- ☐ Frail / Elderly
- ☐ Speech Impediment
- ☐ Physical Disability (Please Explain): _____
- ☐ Bedridden
- ☐ Mentally/Memory Impaired
- ☐ Dementia/Alzheimer's *Full-time caregiver must be present at all times during stay at shelter* (Please indicate Mild, Moderate or Severe) _____
- ☐ Dialysis (Please indicate Hemodialysis at Facility, Hemodialysis at Home or Peritoneal) _____
- ☐ Requires Constant Skilled Nursing Care (e.g., open wounds)
- ☐ Assistance with Medications
- ☐ Assistance Needed with Insulin
- ☐ Requires Refrigerated Medications
- ☐ Medications (Please list all required medications): _____ _____
- ☐ Autism
- ☐ Special Dietary Needs/Restrictions (Please Explain): _____ _____
- ☐ Seizures
- ☐ Other Reason for Needing Assistance (Please Specify): _____ _____

**Transportation Needs:**

*If transportation assistance is required, **please check all** vehicle types that can be used for transportation.*

- ☐ Car
- ☐ Bus
- ☐ Wheelchair Van
- ☐ Ambulance

**Communication Limitations (Check all that apply):**

- ☐ I do not have a radio
- ☐ I do not have a television
- ☐ I do not have a telephone, TTY or VRI
- ☐ I do not have access to the Internet
- ☐ I do not speak English (Provide language you speak): _____

How do you receive emergency notifications?_____ _____

**Has difficulty walking and requires:**

- ☐ Walker/cane
- ☐ Standard wheelchair
- ☐ Motorized wheelchair
- ☐ Motorized Scooter
- ☐ Attendant to assist in walking
- ☐ Requires Stretcher Transportation
- ☐ Hoyer Lift

**Oxygen Dependent:**

*Check all that apply:*

- ☐ 24 Hour (Please specify O2 Type, Liters Flow, O2 Company and Contact Information): _____
- ☐ Only Overnight (Please specify O2 Type, Liters Flow, O2 Company and Contact Information): _____
- ☐ Nebulizer (Please specify O2 Type, Liters Flow, O2 Company and Contact Information): _____
- ☐ CPAP (Please specify O2 Type, Liters Flow, O2 Company and Contact Information): _____
- ☐ Other (Please specify O2 Type, Liters Flow, O2 Company and Contact Information): _____

**Requires medical equipment that is not easily transportable:**

- ☐ Ventilator
- ☐ Suction machine
- ☐ Catheters
- ☐ Feeding Tube
- ☐ Oxygen Concentrator
- ☐ Other equipment (Please Specify):_____