

2011 Coastal Health District - Special Medical Needs Evacuation Registration

NOTE: Please **PRINT** information on both sides of this form and mail it to the return address on the back. **REGISTRATION must be UPDATED and submitted ANNUALLY.**

REQUIRED Personal Enrollment Data:

(One Person Per Form)

Date of Application: _____ New Application or Updated of Existing Application (Circle one)

Name: _____ Sex: M F
 Last _____ First _____ Middle _____

Street Address: _____ Apt _____
 _____ Street _____ City _____ County _____ Zip _____

Mailing Address: _____
 (If different from above) _____ City _____ State _____ Zip _____

Primary phone: (_____) _____-_____ Date of Birth: _____ Age: _____ Weight: _____ lbs
 Height: _____

Cell phone: (_____) _____-_____ Alternate phone number: (_____) _____-_____ TDD? _____

Primary Language: _____ Height: _____ ft. _____ in.

Level of English Proficiency if English is not Primary: _____

Residence Type*: Single Family Mobile Home Apartment/Condo
 Home/Duplex Park/Trailer Other (specify) _____
 Name of subdivision, mobile home park or apartment complex _____

****Residents living in Nursing Homes, Assisted Living Facilities, and Personal Care Homes MUST follow the emergency plan established by the facility's administration.***

Living Situation: Living Alone Living with Parents Living with Children/Family
 Living with Friend Living with Spouse Other (specify) _____

Name of contact in your home: _____

Name of Spouse _____ Is spouse registered? YES NO

Emergency Contacts

(Local) Name: _____ Relationship: _____ Phone: (_____) _____-_____
 Cell: (_____) _____-_____
 (Non-Local) Name: _____ Relationship: _____ Phone: (_____) _____-_____
 Cell: (_____) _____-_____
 (Alternate) Name: _____ Relationship: _____ Phone: (_____) _____-_____
 Cell: (_____) _____-_____

Special Medical Needs

Check All that Apply:

<input type="checkbox"/> Medical Dependence on Electricity	<input type="checkbox"/> Home generator: Y or N	<input type="checkbox"/> Speech Impairment
<input type="checkbox"/> Meds requiring refrigeration	<input type="checkbox"/> Need assistance with some ADLs	<input type="checkbox"/> Morbid Obesity
<input type="checkbox"/> O2 Concentrator, Nebulizer	<input type="checkbox"/> Cognitive Impairment	<input type="checkbox"/> Hearing Loss/Impaired
<input type="checkbox"/> Feeding Pump	<input type="checkbox"/> Mental Health Problem	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Suction	<input type="checkbox"/> Alzheimer's/Dementia	<input type="checkbox"/> Service Animals
<input type="checkbox"/> Other _____	<input type="checkbox"/> Open Wounds/Decubitus	<input type="checkbox"/> Dialysis Dependent
<input type="checkbox"/> Oxygen Company _____	<input type="checkbox"/> Respirator Dependent	<input type="checkbox"/> Immune Deficiency
Use of O2 cylinders:	<input type="checkbox"/> Insulin Dependent Diabetes	<input type="checkbox"/> Chronic respiratory condition
# of days supply of cylinders: _____	<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Assistance with Administration of Med's (including insulin)	<input type="checkbox"/> Bedridden	
<input type="checkbox"/> Walker/Cane/Wheelchair (circle one)	<input type="checkbox"/> Other _____	
	<input type="checkbox"/> Can you climb stairs? Y or N	

Assistance Required

A Caregiver **SHOULD** travel with Registrant. Do you have a caregiver? YES NO
Caregiver Name: _____ Caregiver Phone: (____) _____ - _____

Will your caregiver travel with you on the bus? YES NO

Do you have a pet or service animal that needs to travel with you? YES NO

Do you have proof of vaccination for your pet? YES NO

Do you have a pet carrier for your pet? YES NO

Do you need Transportation to a **Special Needs Staging Area** in the event of a disaster? YES NO

If "YES," Indicate type of Transportation: BUS Wheelchair Van Ambulance

Caregivers will be housed in a Red Cross Congregate Shelter co-located with the Special Needs Shelter!

DEPARTMENT OF PUBLIC HEALTH - COASTAL HEALTH DISTRICT - SPECIAL MEDICAL NEEDS REGISTRATION

Other Medical Information

Primary Doctor Name: _____ Phone: (____) _____ - _____

Home Health Agency Name: _____ Phone: (____) _____ - _____

Pharmacy Name: _____ Phone: (____) _____ - _____

Health Insurance Company Name: _____ Phone: (____) _____ - _____

Allergies: _____

Routine Medications: _____

Physical Limitations: _____ Other Medical Conditions: _____

Dependencies (Medical Equipment): _____

Personal Emergency Evacuation Plan

In the event of an evacuation of your community, you prefer to:

_____ Stay at Home
Do you have all necessary medications, equipment, emergency supplies? Y or N
If you require a Caregiver, who will it be: _____

_____ Stay with family/friends
Name: _____
Address: _____
Phone: _____

_____ Go to a shelter
Who will be your Caregiver: _____
Do you have a service animal that will accompany you to the shelter? Y or N
If yes, approximate size in pounds: _____
Will your Caregiver stay with you at the shelter? Y or N
Total number of people who would accompany you to a shelter: _____

_____ Other: (specify) _____

Do you have or can you arrange your own transportation? Y or N
If no, Can you sit up and ride in a bus or van? Y or N
Do you need a wheelchair lift? Y or N
Do you require an ambulance for transportation? Y or N

Number of pets in your home (other than any Service Animal indicated above): Dog _____ Cat _____

In the event of an evacuation of your community, your plan for your pets is:

_____ Stay in your home Who will be their caretaker: _____

_____ Stay with family/friends: Name _____
Address: _____ Phone _____

_____ Accompany you to a pet-friendly shelter

_____ Other: (specify) _____

Activities of Daily Living Functional Assessment

Check appropriate box for each activity:

ACTIVITY	0	1	2	COMMENTS
Eating				
Bathing				
Grooming				
Dressing				
Transferring				
Continence				

KEY: 0 = can do without assistance
 1 = needs some assistance
 2 = cannot perform the activity

Consent

By signing this form, I agree that the information contained is accurate and truthful to the best of my knowledge.

Signature: _____ Date: _____

Person Completing this Form? Self Other (name and Phone number): _____

Address/Company: _____ Phone: (_____) _____

IMPORTANT NOTES:

- In an actual emergency, coordinating agencies will try to provide the necessary evacuation assistance, but this cannot always be assured.
- To best guarantee personal safety, individuals should make plans and follow government emergency evacuation guidelines.
- The purpose of a Special Needs Shelter is to provide emergency sheltering for persons with **QUALIFIED** medical conditions. A personal caregiver **SHOULD** accompany registered individuals to a Special Needs Shelter.
- Nursing homes, personal care homes, and assisted living facilities are **REQUIRED** by law to have plans which address evacuation and sheltering of their residents. Residents in these categories are **NOT** eligible for evacuation to Special Needs Population Shelters.
- Registrants must arrange local transportation to from their place of residence to the Special Needs Staging Area to the best of their ability.

All information contained in this form is confidential and exempt from disclosure. This completed form will **ONLY** be shared with emergency responses agencies providing service to you.

Mail Completed Form to the following address in your county of residence. For more information about the Special Needs Registry, call the phone number for your county, listed below:

Bryan County Health Dept.
ATTN: Joanne Burnsed
P. O. Box 9
Pembroke, GA 31321-0009
912-653-4331

Camden County Health Dept.
ATTN: Debbie Melton
905 Dilworth Street
St. Marys, GA 31558
912-882-8515

Chatham County Health Dept.
ATTN: Cathy Schmid
1395 Eisenhower Drive
Savannah, GA 31406
912-356-2441

Effingham County Health Dept.
ATTN: Cindy Grovenstein
P.O. Box 350
Springfield, GA 31329
912-754-6484

Glynn County Health Dept.
ATTN: Sharon Smith
2747 4th Street
Brunswick, GA 31520
912-279-3350

Liberty County Health Dept.
ATTN: Annie Washington
P.O. Box 231
Hinesville, GA 31310
912-876-2173

Long County Health Dept.
ATTN: Kathy Rowell
P.O. Box 279
Ludowici, GA 31316
912-545-2107

McIntosh County Health Dept.
ATTN: Paige Lightsey
P.O. Box 231
Townsend, GA 31331
912-832-5473