

2009 Coastal Health District - Special 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 Home/Duplex Mobile Home Park/Trailer Apartment/Condo 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:

Medical Dependence on Electricity

Meds requiring refrigeration

O2 Concentrator, Nebulizer

Feeding Pump

Suction

Other _____

Oxygen Company _____

Use of O2 cylinders:

of days supply of cylinders: _____

Assistance with Administration of Med's (including insulin)

Home generator: Y or N

Need assistance with some ADLs

Cognitive Impairment

Mental Health Problem

Alzheimer's/Dementia

Open Wounds/Decubitus

Respirator Dependent

Insulin Dependent Diabetes

Hypertension

Bedridden

Other _____

Speech Impairment

Morbid Obesity

Hearing Loss/Impaired

Incontinence

Service Animals

Dialysis Dependent

Immune Deficiency

Chronic respiratory condition

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 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
600 North Charles Gilman Jr. Ave.
Kingsland, GA 31548
912-729-4554

Chatham County Health Dept.
ATTN: Dolores Robertson
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: Betty Dixon
24 Oglethorpe Professional Blvd.
Savannah, GA 31406
912-644-5201