2016 Coastal Health District Functional and Medical Needs Evacuation Registration Form

**Note: Please PRINT the entire form and mail it to the return address at the end of the form. Registration must be updated and submitted annually.**

Required Personal Enrollment Data  
 Section 1 (One Person Per Form)

Z9One

**Date of Application**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **New Application** or **Updated** Version of Existing Application (circle one)

**Name:**   
Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sex**:  Male  Female

**Street address**:   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Street City State Zip Apt. County

**Mailing address (if different from above**):   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 City State Zip

**Primary phone**: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_ **Alternate phone**: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_ **TDD** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**: \_\_\_ / \_\_\_ / \_\_\_\_\_\_ **Age**: \_\_\_\_\_\_ **Weight**: \_\_\_\_\_\_\_\_ lbs. **Height:** \_\_\_\_\_\_\_\_ ft. \_\_\_\_\_\_\_\_ In.

**Primary language**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Level of English proficiency, if English is not primary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Residence type**:  Single family home/duplex  Mobile home park/trailer  Apt. /Condo

 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name of subdivision, mobile home park, or apartment complex \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\* Residents living in nursing homes, assisted living facilities, and personal are 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 (Is spouse registered? Y / N)  Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of contact in home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Spouse (If Applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Filling out Form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Section 2 Emergency Contacts

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**(Local) Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

**Phone**: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

**(Non-Local) Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationshi**p: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

**Phone:** (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

(**Other) Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationshi**p: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

**Phone:** (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Section 3 Functional Needs

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**Check all that apply:**   
 Medical dependence on electricity  Yes  No

 O2 concentrator  Nebulizer  Feeding Pump  Suction  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Oxygen Company (Provider Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Phone)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Intellectual disabilities  Allergies to foods  Bedridden  
 Cognitive impairment  Dietary restrictions  Weight  Morbid obesity  
 Speech Impairment  Service animal  Incontinence  Alzheimer’s/Dementia   
 Anxiety/depression  Hearing loss/impaired  Vision loss/impaired  Mental Health Problem  
 Walker/Cane/Wheelchair (circle one)  Communication aids/services  
 List any devices \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Activities of daily living require:**  
 Durable medical equipment (DME) (Provider Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Phone)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assistance with medications ( Refrigeration required)   
 Consumable medical supplies (CMS) (Provider Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Phone)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Personal Assistance Services (PAS) (Provider Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Phone) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Sleeping accommodations**

 Accessible cots  Crib  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Access to transportation:**   
 Wheelchair accessible vehicle  Individualized assistance  Transportation assistance required

**Assistance with activities of daily living:**  
 Eating  Taking medication  Dressing/undressing  Walking  Stabilization  Climb Stairs  
 Transferring to/from wheelchair or other mobility aid  Bathing  Toileting  Communication aids / needs

Section 4 Medical Needs

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**Check all that apply:**  
 IV medication  Feeding pump  Suction   
 Requires medical observation  Open wounds/decubitus  Unstable   
 Respirator dependent  Contagious condition  Terminal   
 Chronic condition  Immune deficiency  Ongoing treatment  
 Dependent on power operating equipment to sustain life  
 Other (Please specify on lines below) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Medical Diagnosis: (i.e. insulin dependent diabetes, dialysis, hypertension, chronic respiratory conditions) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requires licensed care provider to perform the following: ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Section 5 Medications

Z9One

**Please list your current medication(s). Please include prescription and non-prescription.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Section 6 Additional Required Information

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A caregiver MUST travel with registrant. Do you have a caregiver?  Yes  No  
 Caregiver name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Caregiver phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_   
 Will your caregiver travel with you?  Yes  No   
 Do you have a pet or service animal that needs to travel with you?  Yes  No  
 What type of service animal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 What type of pet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Do you have proof of vaccination for your pet?  Yes  No  
 Do you have a carrier for your pet?  Yes  No  
 Do you need transportation to the staging area (area from which evacuation will take place) in the event of a disaster?  Yes  No  
 If yes, indicate type of transportation:  Bus  Wheelchair van  Ambulance

Section 7 Provider and Insurance Information

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Primary doctor name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_   
Home health agency name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_   
Other health service provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Other health service provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_   
Pharmacy name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_   
Medicaid: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_   
Medicaid ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Waiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_   
Medicare: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_   
Medicare ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_   
Health Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_   
Insurance policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Insurance group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Case manager (name and organization):   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_   
 E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Important Notes

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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.
* Your personal caregiver **MUST** accompany you to the emergency shelter.
* Depending on your health status you may be transported to an American Red Cross emergency shelter or admitted to an inland healthcare facility.
* **Residents living in a nursing home, assisted living facility and personal care home MUST follow the emergency plan established by the facility’s administration.**

Consent to Participate in the Functional/Medical Needs Registry

Z9One

Please read and initial each of following. Refusal to sign does not mean you will not be placed on the Registry. It may, however, affect our ability to process this application **and** our ability to assist you.

\_\_\_\_\_ I recognize that neither the County Department of Public Health, County Emergency Management Agency, nor any of their partners are responsible for providing medical care for evacuees and that the intent of the Functional/Medical Needs Registry is to provide, to the extent possible under emergency conditions, an environment in which the current level of health of the evacuees with functional or medical needs can be sustained within the capabilities of available resources.

\_\_\_\_\_ I recognize that completion of this application does not guarantee my placement in the Functional/Medical Needs Registry, and that even if I am placed on the Registry, I remain responsible for myself in the event of a disaster.

\_\_\_\_\_ I assume responsibility for updating the County Functional/Medical Needs Coordinator regarding any changes in my medical status or contact information (phone number, address, etc.). Even if no changes in my status occur, I agree to contact the Coordinator at least annually.

\_\_\_\_\_ I am completing and submitting this application of my own free will.

\_\_\_\_\_ I give local law enforcement and emergency services personnel permission to enter my home in the event of an emergency.

\_\_\_\_\_ I authorize the contact of the person(s) I have listed herein as my emergency contact in the event of an emergency.

\_\_\_\_\_ I have read and signed the “Authorization for Release of Protected Health Information” form used to assist public health and their partners in facilitating my evacuation and sheltering needs during an emergency.

\_\_\_\_\_ I had the opportunity to ask questions regarding the use of my health information and obtain a Notice of Privacy Policy form upon request.

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

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person completing this form:  Self  other (name and phone number): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address/Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

**Please print and return to:   
McIntosh County Health Dept.   
Attn: Brooke Deverger  
P.O. Box 231  
Townsend, GA 31331**

This section to be completed by Coastal Health District.

Date\_\_\_\_\_\_\_\_\_\_ Date Updated \_\_\_\_\_\_\_\_\_ County \_\_\_\_\_\_\_\_\_ Evac Zone \_\_\_\_\_\_\_\_\_ Triage \_\_\_\_\_\_\_\_\_

Z9One