

General Medical Conditions:

<input type="checkbox"/> I use Insulin for <i>DIABETES</i>		<input type="checkbox"/> Severe arthritis
<input type="checkbox"/> I use Oral Medication for <i>DIABETES</i>		
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Complete <input type="checkbox"/> Partial	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Home Dialysis <input type="checkbox"/> Dialysis Center	<input type="checkbox"/> Heart condition
	Number of times dialyzed per week: _____.	<input type="checkbox"/> Deaf /hearing impaired
	Name of dialysis center: _____	<input type="checkbox"/> Blind (guide dog <input type="checkbox"/>)
<input type="checkbox"/> Open wounds that require dressing changes.	How often? _____	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Pregnant?	Due date: _____	<input type="checkbox"/> Ostomy
<input type="checkbox"/> Medications that require refrigeration? _____		<input type="checkbox"/> Memory impairment
		<input type="checkbox"/> Electric Dependent
		<input type="checkbox"/> Other: _____

Medication List (Additional sheets can be e-mailed to: [swishard @ircgov.com](mailto:swishard@ircgov.com))

Prescription Medications			Over-the-counter (OTC) medications		
Rx Name	Dose	How Often	OTC Name	Dose	How Often

SPECIAL NOTES

As a special needs shelter evacuee, I am entitled to pre-authorize emergency response personnel to enter my home during search and rescue operations, if necessary, to assure my safety and welfare following a disaster as defined in Florida Statutes 252.34.

Yes, I do pre-authorize. No, I will not pre-authorize.

I understand that the Special Needs Shelter will not be air conditioned if emergency power is required.

I understand that I need to bring with me all medications, in marked bottles, and all medical supplies I use for my care for up to 14-days (two weeks).

I understand that I must bring my own bedding. The Special Needs Shelter will not supply cots or other bedding.

Part of my emergency plan includes designating alternate living arrangements (home of friend or relative, etc.) in the event my home is severely damaged and I am unable to return.
My alternate plan is to temporarily reside at the following location:

I understand that once this public shelter has been closed following the emergency event, it will be my responsibility to either return home or seek other living arrangements.

READ AND SIGN

To the best of my knowledge, I certify that this information contained herein is true and correct. I understand that based on this application and the data I have provided, the Department of Emergency Services will determine which emergency evacuation assistance, if any, this program may be able to provide. Further, I grant permission to medical providers, transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs.

Signature: _____	Date: _____
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APPLICANT REPRESENTATIVE

If the person completing this form is not the applicant, please answer the following:

Name: _____	Relationship/Agency: _____	Date: _____
Phone: _____	Applicant has been notified of this registration: Yes <input type="checkbox"/> No <input type="checkbox"/>	

OFFICIAL USE ONLY

Reviewed By: _____	Date: _____	Category: _____	Sector #: _____
Applicant Contacted: _____	Pre-Registered: <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Stay: <input type="checkbox"/> Patient <input type="checkbox"/> Caregiver	
Type of Shelter: <input type="checkbox"/> Regular <input type="checkbox"/> SNS <input type="checkbox"/> Hospital <input type="checkbox"/> Hospice	<input type="checkbox"/> Patient/Caregiver		

*****Return Application to*****

IRC Dept. of Emergency Services (ATTN: SNS)
4225 43rd Avenue
Vero Beach, FL 32967

Questions? Call (772) 567-2154

On-Line form: www.irces.com