# ORANGE COUNTY HEALTH SERVICES DEPARTMENT
# PEOPLE WITH SPECIAL NEEDS PROGRAM
# REGISTRATION FORM

**Personal Information for Individual with Special Needs**

First Name _____ Last Name _____

Home Address _____ Apt/Lot No. _____ City _____ State _____ Zip Code _____

Residence Type: ○ Single Family Home ○ Mobile Home ○ Multi-Family Home ○ Apartment ○ Other _____

Name of Subdivision/Condo/Mobile Home/Apartment Complex _____

Primary Phone ( ) _____ ○ Primary Phone is TTY/TTD Secondary Phone ( ) _____

○ I Do Not Have A Phone Email Adress: _____

Date of Birth: _____ Gender: ○ M ○ F Height: _____ Weight: _____ lbs.

Primary Language _____

**Mailing Address (Please enter if Different than your Physical Address)** ○ Same as Physical Address

Mailing Address _____ Apt/Lot No. _____ City _____ State _____ Zip _____

**Emergency Contact(s) Information:**

Primary Contact

First Name _____ Last Name _____ Relationship: _____

Primary Phone ( ) _____ Secondary Phone ( ) _____ ☐ Checking this box allows medical information to be shared with this contact.

Secondary Contact

First Name _____ Last Name _____ Relationship: _____

Primary Phone ( ) _____ Secondary Phone ( ) _____ ☐ Checking this box allows medical information to be shared with this contact.

## Transportation Needs:

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

○ Car ○ Bus ○ Wheelchair Van ○ Ambulance

Has difficulty walking and requires: ○ Walker / Cane ○ Standard Wheelchair ○ Motorized Wheelchair

○ Motorized Scooter ○ Attendant to assist in ambulating ○ Requires Stretcher Transportation

## Caregiver and Family Information

Caregiver Name:_____ Caregiver's Phone:_____

Do you require a 24 hour caregiver? ○ Yes ○ No Will your caregiver travel and/or stay with you? ○ Yes ○ No

How many family members (who live in your home) will accompany you if you choose to seek shelter? _____

## Medical Providers:

Physician's Name_____ Physician's Phone: _____

Pharmacy Name_____ Pharmacy Phone: _____

Home Health Care Agency Name_____ Home Health Care Agency Phone: _____

Medical Equipment Provider Name_____ Medical Equipment Provider Phone: _____

Oxygen Provider Name:_____ Oxygen Provider Phone:_____

## Service Animals / Pets

Do you own an animal? ○ Yes ○ No What type of animal? ○ Dog ○ Cat ○ Minature Horse ○ Other_____

Is this animal a service animal (eg. a seeing eye dog)? ○ Yes ○ No Is this animal an emotional support animal? ○ Yes ○ No

Animal's Name _____ Breed/Description: _____ Weight _____

Is there a carrier cage available? ○ Yes ○ No Is there a leash available? ○ Yes ○ No Is there a muzzle available? ○ Yes ○ No

*Additional animals/pets should be listed in Comments.*

Medical Conditions: (Select All That Apply)

| | | | | | |
|---|---|---|---|---|---|
| ○ Alzheimer Disease<br>_____Mild<br>_____Severe | ○ Ambulating Difficulties | ○ ALS<br>____Early Stage<br>____Middle Stage<br>____Late Stage | ○ Aphasia | ○ Apnea Monitor | ○ Assistance with Daily Living |
| ○ Asthma | ○ Arthritis | ○ Autism | ○ Bedridden | ○ Behavioral Health Issues | ○ Blind |
| ○ Cancer<br>___Chemotherapy<br>_____End Stage | ○ Cardiac<br>____Stable<br>____Unstable | ○ Catheter | ○ Cerebral Palsy | ○ COPD | ○ Colostomy/ Ileostomy |
| ○ Comatose | ○ Contagious Disease | ○ Cystic Fibrosis | ○ Deaf/ Hard of Hearing | ○ Dementia<br>_____Mild<br>____Moderate<br>____Severe | ○ Diabetes<br>_____Insulin Dependent<br>____Non-Insulin Dependent |
| ○ Dialysis<br>____At Facility<br>____At Home<br>____Peritoneal | ○ Eating and Swallowing Disorder | ○ Edema | ○ Emphysema | ○ Feeding Tube | ○ Fractured Bones |
| ○ Frail Elderly | ○ High Blood Pressure | ○ Hip/Knee Replacement<br>____Non-Ambulatory<br>____Confined to Bed | ○ Hoyer Lift | ○ Incontinence | ○ IV Care |
| ○ Mentally/ Memory Impaired | ○ Multiple Sclerosis | ○ Muscular Dystrophy | ○ Nebulizer | ○ Neuromuscular Disorder | ○ Oxygen User<br>_____Tanks<br>___Concentrator<br>____Overnight<br>____As Needed |
| ○ Paralysis | ○ Parkinson's Disease | ○ Pulse Oximeter | ○ Respirator Vent Dependent | ○ Seizures | ○ Sleep Apnea/ CPAP User |
| ○ Speech Impediment | ○ Stroke | ○ Suction Machine | ○ Terminal Endstage | ○ Tracheostomy Tube | ○ Wheelchair Permanent |
| ○ Wounds/ Sores/Rashes | ○ Other | | | | |

## *Additional Comments / Information*

Please enter any additional information that may be useful for our emergency personnel to evacuate this person.

## *Acknowledgement*

The following statements provide information on how Orange County handles your Personal Health Information (PHI). They will not impact the receipt of services during time of hurricanes or disasters.

It is crucial to our response efforts that the information you provide be as accurate and up to date as is possible. You will be contacted periodically to verify and ensure the information provided is correct and to make any necessary changes. Individual forms will need to be updated on an annual basis to remain active on the registry.

This information will only be released to emergency response agencies for assistance during emergency and disaster situations; and I understand that emergency responders may enter my home and provide for my needs in an emergency situation.

*This form was completed by:*

| | | |
|---|---|---|
| ☐ Special Needs Client: | Client Signature _____ | Date _____ |
| ☐ Family Member: | Name:_____ | Phone No._____ |
| ☐ Case/Social Worker: | Name:_____ | Phone No._____ |
| ☐ Health Care Proxy: | Name:_____ | Phone No._____ |
| ☐ Other: | Name:_____ | Phone No._____ |

**Return Completed Forms to:**
**Orange Co Special Needs Program**
**2002-A E. Michigan Street**
**Orlando, FL 32806**
**FAX: (407) 836-2838**