2017 OKEECHOBEE COUNTY
SPECIAL NEEDS SHELTER REGISTRATION REQUEST FORM

Submit Forms To: Florida Department of Health Okeechobee County, Special Needs Shelter, 1728 N.W. 9th Ave., Okeechobee, FL 34972-4340 Ph 863-462-5800

*****FORMS NEED TO BE COMPLETED ANNUALLY BEGINNING MARCH 1ST*****

NAME: (Please Print)_____DATE Of BIRTH: _____

STREET: _____

CITY: _____ ZIP: _____ PHONE (Including Cell#):_____

☐ MALE ☐ FEMALE HEIGHT: _____ WEIGHT: _____ lbs. AGE: _____

PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Other – Specify _____

HOME CARE INFORMATION

☐ I take care of myself at home ☐ I need part time nursing help at home

☐ I am unable to care for myself at home ☐ I have full time nursing help at home

CAREGIVER THE FOLLOWING PERSON **WILL BE ASSISTING ME IN THE SHELTER**:

_____RELATIONSHIP: _____

CAREGIVER'S PHONE NUMBER(s) - (Including Cell#): _____

TYPE OF RESIDENCE: ☐ Single Family Home ☐ Manufactured Home ☐ Apartment/Condo

Subdivision/Complex/Park Name: _____

Office Phone Number: _____

PHYSICIAN/PROVIDERS

PRIMARY DOCTOR (Full Name)

_____ PH#_____

HOME HEALTH/HOSPICE AGENCY (Full Name)

_____ PH#_____

OXYGEN PROVIDER (Full Name)

_____ PH#_____

OTHER MEDICAL SUPPORT PROVIDERS

PHARMACY: _____ PH#_____

HOME MEDICAL EQUIPMENT: _____ PH#_____

DIALYSIS: _____ PH#_____

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SPECIAL/MEDICAL NEEDS – Please mark all that apply

- ☐ Wound care daily or more often Type of wound: _____
- ☐ Ostomy care assistance
- ☐ Catheter care assistance
- ☐ Suction equipment
- ☐ Feeding Pump
- ☐ Assistance from RN with medication or injections
- ☐ Assistance from RN with insulin and checking blood sugar
- ☐ RN to assist with IV's ***Include copy of order from Physician**
- ☐ Ventilator dependent (stable)
- ☐ Medicines that require refrigeration
- ☐ Medical electrical equipment required to maintain health status:
  ___ CPAP/ BI-PAP ___ Nebulizer ___ Other _____
- ☐ Oxygen dependent: ____ 24 hr. ____ Nighttime ____ PRN Liters per minute _____

***Prescription or written instructions ***

OTHER NEEDS - Please mark all that apply

Please make sure to bring the following items with you and make sure that your name is on them

- ☐ Glasses
- ☐ Hearing aide(s) ___ Right Ear ___ Left Ear ___ Both Ears
- ☐ Cane*
- ☐ Walker*
- ☐ Wheel chair*
- ☐ Electric wheel chair*
- ☐ Trained service animal Type of Animal_____
  What work or task has the animal been trained to perform? _____
  _____

MEDICAL AND ADDITIONAL INFORMATION – Please mark all that apply

- ☐ Seizures
- ☐ Diabetes
- ☐ Cardiac please specify: ___ Congestive Heart Failure ___ Angina ___ High Blood Pressure ___ Stroke
- ☐ Dialysis – If checked, please specify ___ Hemodialysis ___ Peritoneal
- ☐ Quadriplegic or Paraplegic – If checked, please specify:_____
- ☐ Mental Illness – If checked, please specify: _____
- ☐ Anxiety/ Depression
- ☐ Alzheimer's /Dementia – If checked, please specify: **Full time caregiver must be present at all times during sheltering.**
- ☐ Immune System Problems – If checked, please specify: _____
- ☐ Bed bound
- ☐ Unable to transfer bed to chair
- ☐ Unable to hold urine or bowel movements until bathroom is reached
- ☐ Do Not Resuscitate Order (DNRO) **(Bring original copy with you**)

MEDICATIONS

Please list your medications, your dosage, full name of the doctor who prescribed the medication and the doctor's phone number. **Attach additional paper if necessary.**

NAME OF MEDICATION	DOSAGE	FULL NAME OF PRESCRIBING PHYSICIAN	PHYSICIAN'S PHONE NUMBER (include area code)

TRANSPORTATION REQUIREMENTS

- □ I (we) have our own transportation and will drive to the shelter
- □ I (we) request transportation via van.
- □ I (we) request transportation via van/wheelchair lift
- □ I (we) request transportation via ambulance stretcher

If you are requesting transportation, please answer the following questions:

If using a wheelchair, can you transfer to a van seat? □ Yes □ No

If a stretcher is needed, please explain why

_____

_____

List equipment your life depends on that must be transported with you (such as oxygen concentrators):

_____

How many people going to the shelter: _____ Number to be picked up: _____

ALTERNATIVE ARRANGEMENTS

Should your home sustain damage and you are not able to immediately return home, please list what your plans are and who can be contacted that you can stay with. Please list their names and phone numbers (including cell numbers). Please list at least one "Non-Local" contact in the event that our area needs to be evacuated.

Sheltering plan after an event:

_____

_____

_____

Contact Person: _____ Phone Number(s): _____

Contact Person: _____ Phone Number(s): _____

Contact Person (Non-Local): _____ Phone Number(s): _____

SIGNATURE

I have read, understood and received a copy of the "Important Notice and Statement of Understanding".

I grant permission to health care providers, transportation agencies, and others as necessary to provide care, and to disclose any information that is necessary to respond to my needs.

I understand that this registration is voluntary and hereby request registration in the Special Needs Shelter.

_____

Signature of Registrant or Guardian Date

******THIS FORM MUST HAVE A SIGNATURE*****

TO BE COMPLETED BY OKEECHOBEE COUNTY HEALTH DEPARTMENT STAFF

- ☐ Meets criteria for Special Needs Shelter
- ☐ Nursing Home/Assisted Living Facility
- ☐ Hospital
- ☐ General Shelter

Signature: _____ Date:_____

KEEP THIS SHEET- DO NOT RETURN WITH REGISTRATION

IMPORTANT NOTICE AND STATEMENT OF UNDERSTANDING

PLEASE KEEP THIS SHEET FOR FUTURE REFERENCE. DO NOT RETURN WITH THE SHELTER REGISTRATION REQUEST FORM.
THANK YOU

I understand that:

- Emergency shelters, including the Special Needs Shelter, are made available to provide protection during immediate danger and should be considered a shelter of last resort (no other options are available).
- Limited nursing and medical assistance in the Special Needs Shelter will be available to assist me and/or my caregiver.
- Due to the limitation of services and conditions in a shelter, the level of services will not equal what I receive at home; and conditions in the shelter may be stressful and may even be inadequate for my needs.
- I am responsible to provide for my own basic and special needs while in the shelter.
- Patients will be accommodated on simple cots. Air mattresses, lawn and lounge chairs cannot be allowed due to lack of space.
- One person should accompany the patient as a caregiver. Unfortunately, cots cannot be provided to caregivers because this would limit the shelter capacity for patients.
- Patients must bring medications, all medical supplies and medical equipment (including oxygen concentrators) with them to the shelter. Medications must be in their original containers.
- Food may be provided. Special needed dietary items may be brought. Items need to be non-perishable.
- Patient's and caregivers should bring personal hygiene items and extra clothing for 72 hours. Keep in mind that minimum space is available. **Make sure that your name is on all items** brought to the shelter. Patients/caregivers are responsible for their own items.
- Shelter residents will be provided with a list of shelter rules that must be followed. The list includes no smoking in the shelter or on the shelter grounds.
- Pets are not permitted in the shelter and arrangements for their care, while I am in the shelter, should be arranged in advanced. Trained service animals are admitted to the shelter and a 72 hour supply of non-perishable food is to accompany the animal.
- Patients with living wills and Do Not Resuscitate Order (DNRO) forms should bring a copy.
- Local emergency information will be broadcasted through the local radio station
- Transportation is coordinated through Okeechobee County Emergency Management. All attempts will be made to give advance notice by phone, of the date and time to expect to be picked up for transport to a shelter. If I decline transportation when the transporter arrives, I understand that I may not have another opportunity to request this service.
- I will be responsible for any charges and costs associated with hospitalization or other medical facility including care and medical transportation, if they should become needed.
- I will need to make alternative arrangements in the event that I am unable to return to my home after the storm.
- I grant permission to health care providers, transportation agencies, and others as necessary to provide care, and to disclose any information that is necessary to respond to my needs.
- I understand that this registration is voluntary.

PLEASE KEEP THIS SHEET FOR FUTURE REFERENCE.
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THANK YOU