

Polk County Emergency Management Division
Special Needs Shelter Registration
Gayle Cather, RN, MS, Special Needs Coordinator
1295 Brice Blvd., Bartow, Florida 33830

Agency _____

Name _____ Date of birth _____

Physical address _____ Complex name _____

Apt/Lot# _____ Floor _____ City _____ Zip _____

P.O. Box _____ Phone _____ TDD number _____

Mobile Home Yes No Live alone Yes No Wheelchair ramp Yes No House Steps _____

Local Emergency Contact _____ Phone _____

Accompany _____ Doctor _____ Phone _____

- _____ Transportation Public Shelter
- _____ Transportation Special Needs Shelter not required (will drive self/family)
- _____ Transportation Special Needs Shelter
- _____ Transportation Hospital/Nursing Home through Emergency Management coordination

Medical/Physical Condition _____ Diabetic Yes No

Blind _____ Legally blind _____ Hearing Impaired _____ Medical assist animal _____

Medical Equipment _____

Dialysis Treatments per week 1 - 2 - 3 Dialysis treatments at home _____

Medications _____

Allergies _____ Medication assistance Yes ___ No ___

OXYGEN liter flow - 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 (circle) Oxygen concentrator Yes ___ No ___

Mobility - Ambulatory _____ Feed self Y / N Special Diet
Ambulate with assist _____ Crutches/Cane/ Walker (CIRCLE)
Wheelchair _____ Ambulate to rest room alone? Y / N
Bedridden _____ **Requires Hoyer Lift** Y / N

If Bedridden - Evacuated by - **Stretcher** or Wheelchair (CIRCLE)

Comments/Directions _____

Do Not Resuscitate (DNR) - please bring with you to the shelter.

Permission to release above information to emergency response agencies *during an emergency*:

Yes _____ No _____ Signed _____ Date _____

Completed by: _____

Special Needs Activation
To Be Completed at Shelter

Date/ time arrival to shelter _____

Transportation _____ Transit Services _____

Accompanied by _____

Caregiver _____

Next of Kin _____

Medications Name	Dosage	Route	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical equipment brought to shelter _____

OXYGEN liter flow _____ Oxygen Company _____

Oxygen _____

Equipment _____

Medical Treatments _____

Bowel & Bladder ___ Independent/continent ___ Partial assist ___ Total care/incontinent

Additional items brought by resident _____

Discharged to _____ Comments _____
Date _____

Equipment _____

By _____