

**SUMTER COUNTY EMERGENCY MANAGEMENT  
SPECIAL NEEDS REGISTRATION**

Office Use

**CONFIDENTIAL**

This information is not subject to public disclosure under Florida Statutes 252.355

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PLEASE PRINT OR TYPE CLEARLY

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

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Mid. Initial) \_\_\_\_\_

Home Address: \_\_\_\_\_ Soc.Sec.# \_\_\_\_\_

City : \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Permanent ( ) Temporary ( ) From: \_\_\_\_\_ To: \_\_\_\_\_ Phone #: \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Primary Language: \_\_\_\_\_

**Emergency Contact:**

Last: \_\_\_\_\_ First: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

**Emergency Contact:**

Last: \_\_\_\_\_ First: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

**Directions to Residence:**

\_\_\_\_\_

**Living Situation:** ( ) Lives Alone ( ) With Parents ( ) With Children ( ) Other \_\_\_\_\_

**Check all applicable characteristics:**

- |  |                               |                           |
|--|-------------------------------|---------------------------|
| ( ) Dialysis Dependent , how often _____   | ( ) Sight Impaired            | ( ) Walker/Cane           |
| ( ) Respirator Dependent (e.g. ventilator) | ( ) Hearing Impaired          | ( ) Bedridden             |
| ( ) Life-Sustaining Medications            | ( ) Speech Impaired           | ( ) Wheelchair Bound      |
| ( ) Med. Dependence on Electricity         | ( ) Memory Impaired           | ( ) Special Dietary Needs |
| ( ) Insulin Dependent                      | ( ) Emergency Alert Equipment | ( ) Mobile Home/Trailer   |
| ( ) Oxygen Dependent                       | ( ) Cardiac History           | ( ) No Alternate Housing  |
| ( ) Concentrator Y____ N____               |                               | ( ) Weight <300 pounds    |

Do you have back-up oxygen tanks? Y\_\_\_\_ N\_\_\_\_ Size \_\_\_\_\_ Liter Flow \_\_\_\_\_

Service Animal Y\_\_\_\_ N\_\_\_\_

Additional Medical Information or Special Concerns \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Transportation:**

- ( ) Provide Own Transportation to Shelter  
( ) Need Assistance with Transportation  
( ) Regular ( ) Van w/wheelchair lift ( ) Ambulance w/stretchers

Name of person (if any) going with you to the shelter: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**OPTIONAL: PRE-AUTHORIZATION TO ENTER HOME BY EMERGENCY PERSONNEL**

I authorize emergency response personnel to enter my home during search and rescue operations following a disaster, if necessary, to assure my safety and welfare.

Authorized Signature: \_\_\_\_\_

**AGENCY USE ONLY: if you are representing a client please complete the following: PLEASE PRINT CLEARLY**

Agency Name: \_\_\_\_\_

Agency Address: \_\_\_\_\_

Agency Telephone # : \_\_\_\_\_ Name of person completing form: \_\_\_\_\_

Mail form to:

Sumter County Emergency Management - 1010 N. Main Street - Bushnell, FL 33513-5441

Office# 352-569-6000 Fax # 352-569-1222

Revised 2/17/09