ORANGE COUNTY HEALTH SERVICES DEPARTMENT
PEOPLE WITH SPECIAL NEEDS QUESTIONNAIRE

(This form must be filled out completely in order to register)
Red Box Indicates Required Field

REGISTRANT'S GENERAL INFORMATION

First Name | Middle Name | Last Name

Date of Birth | Gender ☐ Male ☐ Female | Is English Spoken? ☐ Yes ☐ No | If no, what is language spoken?

REGISTRANT'S RESIDENTIAL ADDRESS INFORMATION

Home Address | Apartment/Lot No./Floor/Building

City | County | State | Zip Code +4

Do you live in a: | Mobile Home/Apt Complex/Subdivision Name

REGISTRANT'S MAILING ADDRESS INFORMATION

MAILING ADDRESS IS SAME AS ABOVE ☐

If mailing address is different please provide information below:

Mailing address | Apartment/Lot No./Floor/Building

City | State | Zip Code +4

REGISTRANT'S PHONE AND EMAIL INFORMATION

Home Phone | Cell Phone | Other

E-mail

AGENCY/ CAREGIVER/ EMERGENCY CONTACT INFORMATION

Home Health Agency Name | Home Health Agency Phone

Medical Equipment Supplier | Medical Equipment Supplier Phone

Name of Caregiver who will accompany you to Shelter? | Caregiver Phone Number | Caregiver Cell Phone Number

Emergency Contact Name | Relationship | Emergency Contact Phone

TRANSPORTATION NEEDS AND ADDITIONAL INFORMATION

Will you need transportation assistance in an emergency? ☐ Yes ☐ No

If yes, please check ONE of the following:
- ☐ I can sit in a regular car seat.
- ☐ I can walk but can't climb stairs.
- ☐ I must stay in a wheelchair.
- ☐ I am confined to a bed.

Select all that apply:
- ☐ Guide Dog / Service Animal
- ☐ Walker or Cane
- ☐ Wheelchair / Motorized Wheelchair
- ☐ Use TDD/TTY

Do you own a pet? Specify type of pet.

Would you like emergency preparedness information for your pet? ☐ Yes ☐ No

Registrant's Height ☐ Registrant's Weight ☐

REGISTRANT'S MEDICAL INFORMATION (SELECT THE MOST APPROPRIATE CATEGORY (A, B, C). THEN SELECT ALL CONDITIONS THAT APPLY TO YOU.)

CATEGORY A ☐

Anyone who can walk without assistance and needs no outside professional assistance performing the activities of daily living. Anyone who can provide their own medical care and does not have any life threatening problems.

Mark all that apply:

- ☐ Asthma
- ☐ Arthritis
- ☐ Legally Blind
- ☐ Pacemaker
- ☐ Diabetes
- ☐ Hypertension
- ☐ High Blood Pressure

Other Conditions ☐

CATEGORY B ☐

Anyone requiring minor medical assistance to perform their activities of daily living, who may be accompanied by a caregiver.

Mark all that apply:

- ☐ Alzheimers (Early Stages)
- ☐ Aphasia
- ☐ CAPD-Dialysis
- ☐ Catheter
- ☐ Cerebral Palsy
- ☐ COPD
- ☐ Cancer
- ☐ Congestive Heart Failure
- ☐ Cerebrovascular Accident (CVA)
- ☐ Emphysema
- ☐ G-Tube
- ☐ Hemodialysis
- ☐ Hip Replacement (Recent)
- ☐ IV
- ☐ Knee Replacement (Recent)
- ☐ Muscular Dystrophy-Severe (MD)
- ☐ Multiple Sclerosis (MS)
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Oxygen Dependent
- ☐ Parkinson's
- ☐ Rashes/Sores (Fluid)
- ☐ Senile Dementia
- ☐ Terminal
- ☐ Wheelchair Permanent

Other Conditions ☐

CATEGORY C ☐

Anyone who is permanently restricted to bed with a stable medical condition and requiring ongoing medical supervision. Those people who cannot perform the activities of daily living on their own, nor have a caregiver. Anyone with an unstable medical condition and/or requiring constant medical attention. Anyone on a life support system.

Mark all that apply:

- ☐ Alzheimers (Advanced)
- ☐ Bed Permanent
- ☐ Cardiac (Unstable)
- ☐ Contagious (Severe)
- ☐ Comatose
- ☐ Cystic Fibrosis
- ☐ Psychosis
- ☐ Respirator
- ☐ Seizure
- ☐ Terminal (Endstage)
- ☐ Ventilator

Other Conditions ☐

REGISTRANT'S SIGNATURE

I certify the information provided on this application is correct. I understand there is no cost associated with using the County's disaster evacuation centers or disaster transportation services. However, should my medical condition deteriorate and should I be transported or admitted to a hospital while being evacuated or at an evacuation center, I am responsible for all expenses associated with transportation and admittance to the hospital. I hereby grant permission to Orange County for release of this information to emergency response agencies, medical providers, transportation agencies and other individuals providing me with medical care and disclose any information required to respond to my needs. I understand by signing this form, I grant emergency responders permission to enter my home and provide for my needs in an emergency.

Registrant's Signature ☐ Date ☐

Case Manager Signature, if completing for Client ☐ Date ☐

PLEASE PRINT, SIGN AND SEND COMPLETED FORM TO:

ORANGE COUNTY PEOPLE WITH SPECIAL NEEDS PROGRAM
2002-A E. MICHIGAN STREET
ORLANDO, FL 32806

PHONE: 407-836-9319
FAX: 407-836-7625