# SPECIAL NEEDS REGISTRY PROGRAM REGISTRATION FORM

**Return Completed Form to:**
**Marion County Emergency Management**
**P.O. BOX 1987**
**Ocala, Florida 34478**
**Office (352) 369-8100 Fax (352) 369-8101**

| **PERSONAL INFORMATION** | | | |
|---|---|---|---|
| Last Name: | First Name: | Birth Date: ___/____/_____ | Sex: ☐M ☐F Current Weight _____ Primary Language:_____ |
| Address: | | Apartment/Unit#: | |
| City: | Zip: | Name of Complex/Subdivision: | |
| Type of Residence: ☐Single Family Home ☐Apartment/Condo ☐Mobile Home/Manufactured Home | | | |
| Home Phone:_____ Mobile Phone:_____ E-Mail Address:_____ | | | |
| Home Health Agency Name and Phone Number: _____ | | | |

| **EMERGENCY INFORMATION** | |
|---|---|
| Living Status: ☐Alone ☐With Relative ☐With Caregiver ☐Other (please indicate)_____ | |
| Local Emergency Contact Name: | Local Emergency Contact Phone: |
| Non-Local Emergency Contact Name: | Non-Local Emergency Contact Phone: |
| Will you have a companion/caretaker accompanying you to the evacuation location? ☐Yes ☐No | |
| If Yes, Companion Name:_____ Companion Phone:_____ | |

| **CLIENT INFORMATION** | |
|---|---|
| Do you use oxygen? | ☐Yes (☐Intermittent ☐Continuous) ☐No |
| • If yes, Oxygen Provider:_____ Phone:_____ | |
| Do you use medical equipment that requires electricity to operate? | ☐Yes (☐Intermittent ☐Continuous) ☐No |
| • If yes, specify the equipment that requires electricity: | |
| Do you use medication that requires refrigeration? | ☐Yes ☐No |
| Memory Impared? | ☐Yes ☐No |
| Do you receive dialysis? | ☐Yes (☐At Home ☐At Facility) ☐No |
| Are you confined to a bed? | ☐Yes ☐No |
| Do you require a Hoyer lift to transfer? | ☐Yes ☐No |
| Do you have a service animal? | ☐Dog ☐Miniature Horse ☐No |
| Mobility Device? ☐Yes ☐No If yes, ☐Manual Wheelchair ☐Electric Wheelchair ☐Walker | |
| Do you require transportation to a shelter? | ☐Yes ☐No |
| • If yes, do you require ADA / Wheelchair Lift? | ☐Yes ☐No |
| | |

| **OFFICE USE ONLY** | | | |
|---|---|---|---|
| ☐ SpNS Shelter | ☐ Transportation | ☐Beyond Care | ☐Not Applicable |
| Reviewer Signature: | | Date: | |

By signing up for the Special Needs Registry Program, you are acknowledging that you have read, understood, and agree with the Notice of Privacy Practices for Protected Health Information.