RETURN TO:
Escambia County Public Safety
6575 North W Street
Pensacola, Florida 32505
Phone: 471-6400 Fax: 850-476-3984

PLEASE PRINT LEGIBLY

FOR EMERGENCY MANAGEMENT USE ONLY
Fire District ________ Shelter Type: General / SPNS
Date Entered____________ Entered By __________

Date:_________________________

SPECIAL NEEDS PROGRAM PERSONAL INFORMATION

Will you be requesting to go to a general public shelter (GPS) or Special Needs Shelter (SNS) if evacuated? ☐ GPS ☐ SNS
Will you need transportation to a shelter if evacuated? ☐ Yes ☐ No
If yes, check type of transportation needed: ☐ Standard Vehicle (bus, car) ☐ Wheelchair equipped ☐ Ambulance ☐ Stretcher Capability

Name: ___________________________________ Spouse: ______________________________

Address: ____ Apt/Lot # ___________________

City: ________________ Zip: ____________Phone: _____________ Cell Phone:_______________Email:_____________________________

Do you live in a mobile home/apt? _______ Complex Name: ____

Date of Birth: _____________ Male: _____ Female: _____ Height:______ Weight:_____ ☐ Does not speak English:_________________
(What Language do you speak)

Are you blind or have low vision: ☐ Yes ☐ No Are you deaf or hard of hearing: ☐ Yes ☐ No Do you have a speech impediment ☐ Yes ☐ No
Do you have a service animal: ☐ Yes ☐ No

Check all that apply:

☐ Bedridden	☐ Walker/Cane	☐ Assistance with medications	☐ Special Dietary Needs/Restrictions (explain)________________________________
☐ Mentally/memory impaired	☐ Wheelchair ☐ Standard ☐ Motorized ☐ Motorized scooter	☐ Oxygen ____ 24 hours ____Overnight only ____Liter flow ____Portable tank	☐ Requires medical equipment that is not easily transportable ☐ Ventilator ☐ Suction Machine ☐ Catheters ☐ Feeding Tubes ☐ Other:______________________
☐ Dementia/Alzheimer's	☐ Attendant to assist in ambulating	☐ Assistance needed with Insulin	☐ Requires Refrigerated Medications
☐ Dialysis	☐ IV	☐ CPAP	☐ Incontinence
☐ Requires constant skilled nursing care	☐ Nebulizer	☐ Autism	☐ Other medical assistance needs:___________________________
☐ Are medical conditions temporary or; ☐ permanent			

Medical Qualifying Conditions: (Explain your medical condition below in detail)

List Your Medications

Name	Strength	Name	Strength

General Physician's Name: ________________________________ Phone: ________________________
Home Health/Hospice Care Provider:____________________________ Phone: ________________________
Dialysis Center Location:_________________________________ Phone:________________________
Medical Equipment Provider:_______________________________ Phone:________________________
Oxygen Provider:_______________________________________ Phone:________________________
Pharmacy Information:____________________________________ Phone:_________________________
Local Emergency Contact Person: ___________________________ Phone:_________________________
Out of Town Emergency Contact Person: _______________________ Phone:_________________________

Your caregiver must accompany and remain with you at the Special Needs Shelter.

Caregiver's Name: ____ Relationship: _______________________
Caregiver's Primary Phone:____ Alt Phone: _________________________