SPECIAL NEEDS REGISTRATION FORM

Polk County Special Needs
Emergency Operations Center
1890 Jim Keene Blvd.
Winter Haven, FL 33880

Phone: (863) 298-7027
Fax: (863) 298-7172
Email: specialneeds@polk-county.net

INDIVIDUAL INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB:_____ Gender:_____
Primary Phone: _____ Alternate Phone: _____ Full Time Resident: _____
Street #: _____ Street:_____ City:_____ Zip:_____
Unit/Lot #:_____ Mailing Address (if different)_____
Mobile Home: _____ Park Name: _____ Caregiver: _____
Lives Alone: _____ Emergency Contact:_____ Phone: _____
Primary Language:_____ Pets: _____ Pet Shelter Arranged: _____ Service Animal: _____
Email Address:_____ Height_____ Weight_____

MEDICAL INFORMATION

Stroke: _____ Diabetic: _____ Cognitive Impairment: _____ If yes, what?_____
Wound Care: _____ Cancer: _____ Incontinent: _____ Visually Impaired: _____
Heart Disease: _____ Dialysis: _____ Contagious Disease: _____ Hearing Impaired: _____
List any other medical conditions:_____
List any medical equipment that requires electricity:_____
List of medications:_____

PROVIDER INFORMATION

Home Health Agency: _____ Phone: _____
Physician:_____ Phone: _____
Oxygen Supply Company_____ Phone:_____
Medical Equipment Supply Company_____ Phone:_____
Dialysis Center_____ Phone:_____

OXYGEN DEPENDENT

Oxygen Dependent: _____ Nebulizer: _____ Concentrator: _____ Portable Tank: _____
Hours Per Day: _____ Liter Flow: _____

SPECIAL CIRCUMSTANCES

Bedridden: _____ Ventilator: _____ Assistance with medication: _____
Combative/Violent: _____ Continuous Equipment: _____ Wheelchair: _____
Electric Wheelchair: _____ Hoyer Lift: _____ Walker: _____

TRANSPORTATION

Transportation required: _____ Transportation Only: _____ Ambulance: _____
Wheelchair Lift: _____ Stretcher: _____ How many steps to front door?_____

SHELTER ASSIGNMENT (to be completed by special needs personnel)

Shelter: _____ Transportation: _____

Print Clear

May 2015