State of Florida
Special Needs Registry

Personal Survey Form

The Florida Division of Emergency Management, in coordination with each local emergency management agency in the state, developed a registry to allow residents with special needs to register with their local emergency management agency to receive assistance during a disaster. The statewide registry provides first responders with valuable information to prepare for disasters or other emergencies.

Providing as much information as possible will allow emergency management officials to plan accordingly for future disasters. You will be e-mailed periodically to verify the information provided is correct and to make any necessary changes. Individual surveys will be archived after one year if not verified.

Why should you register?

- ☑ To receive important information from local emergency management officials about evacuations.
- ☑ IT MAY SAVE YOUR LIFE!

Florida Statute 252.905 declares any information furnished by a person or business to the Florida Division of Emergency Management, for the purpose of, being provided assistance with emergency planning is exempt from F.S. 119.07 (1) and s. 24 (a), Art. I of the State Constitution. Information provided through the FL Get a Plan website for the purposes of building a family and/or business emergency plan is therefore exempt from public records requests made of the Division and is only used for the express purpose of allowing visitors to this website to build and maintain family and/or business emergency plans.

Completing the Florida Special Needs Registry does not automatically qualify the individual for a special needs shelter. Additional information will be provided by your local emergency management agency regarding sheltering.

Mail completed forms to you county emergency management office. Contact information can be found at http://www.floridadisaster.org/County_EM/ASP/county.asp.

Floridians are encouraged to prepare for all types of emergencies. Building an individual or family emergency plan is the first step. During an emergency, the government and other agencies may not be able to meet your needs. You should be prepared to take care of yourself and loved ones for a minimum of 72 hours. Those individuals with special needs are encouraged to identify an emergency support network and to build a disaster supply kit. Registering on this website is not a guarantee that emergency officials will be able to assist you in an emergency.

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Your Personal Information

If your address does not reflect your actual physical location, then describe where the location is that emergency personnel can find you.

First Name:_____ **MI:**_____ **Last Name:**_____ **Suffix:**_____

Email: _____
The email address will be utilized to provide annual reminders to update information.

Physical Address:
Please enter the exact full street address ONLY in the space provided (e.g. 123 Anywhere Street). Please enter P.O. Boxes or R.R. #s on the ADDRESS 2 line.

Address:_____

Apt #: _____

City: _____ **State:**_____ **Zip Code:**_____

County:_____ **Municipality:** _____

Mailing Address (Please enter if different than physical address):

Address:_____

Apt #: _____ **P.O. Box:** _____

City:_____ **State:**_____ **Zip Code:**_____

Primary Phone:_____ **Ext.:** _____

Is Primary Phone TTY/TTD (Teletype Device): ☐ Yes ☐ No

Secondary Phone:_____ **Ext.:**_____

☐ I do not have a phone

Date of Birth (MM/DD/YYYY):_____

Height: (Feet)_____ (Inches)_____ **Weight:**_____

Why do you need my height and weight?

It is important that emergency responders be aware of any condition you have that requires either special equipment or additional personnel to safely evacuate you. This includes gathering information on your size (both height and weight).

Gender (Check one): ☐ Male ☐ Female **Eye Color:**_____

Emergency Contact Information

Please provide contact information for an individual with whom we can discuss your situation in the event that an emergency necessitates this. If you would rather not provide an emergency contact, please check:

☐ I choose not to provide emergency contact information.

Primary Contact:

First Name:_____ **MI:**_____ **Last Name:**_____ **Suffix:**_____

Address:_____

Address: _____

City: _____ **State:**_____ **Zip Code:**_____

Emergency contact's relationship to you (check one):

☐ None ☐ Friend ☐ Family Member ☐ Neighbor ☐ Caregiver ☐ Other

Email: _____

Primary Phone:_____ **Ext.:** _____

Secondary Phone:_____ **Ext.:**_____

☐ Checking this box allows medical information to be shared with this emergency contact.

Secondary Contact (Please enter an out-of-area contact):

First Name:_____ **MI:**_____ **Last Name:**_____ **Suffix:**_____

Address:_____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency contact's relationship to you (check one):

☐ None ☐ Friend ☐ Family Member ☐ Neighbor ☐ Caregiver ☐ Other

Email: _____

Primary Phone:_____ **Ext.:** _____

Secondary Phone:_____ **Ext.:**_____

☐ Checking this box allows medical information to be shared with this emergency contact.

Additional Contact Information:

Physician Information:

Name:_____ **Phone:** _____ Ext. _____

Home Health Care Information:

Name:_____ **Phone:** _____ Ext. _____

Caregiver Information:

Name:_____ **Phone:** _____ Ext. _____

Pharmacy Information:

Name:_____ **Phone:** _____ Ext. _____

Home Medical Equipment Provider Information:

Name:_____ **Phone:** _____ Ext. _____

Dialysis Center Information:

Name:_____ **Phone:** _____ Ext. _____

Evacuation Information

If there were an emergency requiring evacuation, you may have difficulty evacuating or being notified of the need for evacuation because of the following conditions (check all that apply):

- ☐ Blind/Low Vision
- ☐ Deaf/Hard of Hearing
- ☐ Behavioral Health Issues
- ☐ Contagious Disease
- ☐ Frail / Elderly
- ☐ Speech Impediment
- ☐ Physical Disability (Please Explain): _____
- ☐ Bedridden
- ☐ Mentally/Memory Impaired
- ☐ Dementia/Alzheimer's *Full-time caregiver must be present at all times during stay at shelter* (Please indicate Mild, Moderate or Severe) _____
- ☐ Dialysis (Please indicate Hemodialysis at Facility, Hemodialysis at Home or Peritoneal) _____
- ☐ Requires Constant Skilled Nursing Care (e.g., open wounds)
- ☐ Assistance with Medications
- ☐ Assistance Needed with Insulin
- ☐ Requires Refrigerated Medications
- ☐ Medications (Please list all required medications): _____ _____
- ☐ Autism
- ☐ Special Dietary Needs/Restrictions (Please Explain): _____ _____
- ☐ Seizures
- ☐ Other Reason for Needing Assistance (Please Specify): _____ _____

Transportation Needs:

*If transportation assistance is required, **please check all** vehicle types that can be used for transportation.*

- ☐ Car
- ☐ Bus
- ☐ Wheelchair Van
- ☐ Ambulance

Communication Limitations (Check all that apply):

- ☐ I do not have a radio
- ☐ I do not have a television
- ☐ I do not have a telephone, TTY or VRI
- ☐ I do not have access to the Internet
- ☐ I do not speak English (Provide language you speak): _____

How do you receive emergency notifications? _____ _____

Has difficulty walking and requires:

- ☐ Walker/cane
- ☐ Standard wheelchair
- ☐ Motorized wheelchair
- ☐ Motorized Scooter
- ☐ Attendant to assist in walking
- ☐ Requires Stretcher Transportation
- ☐ Hoyer Lift

Oxygen Dependent:

Check all that apply:

- ☐ 24 Hour (Please specify O2 Type, Liters Flow, O2 Company and Contact Information): _____
- ☐ Only Overnight (Please specify O2 Type, Liters Flow, O2 Company and Contact Information): _____
- ☐ Nebulizer (Please specify O2 Type, Liters Flow, O2 Company and Contact Information): _____
- ☐ CPAP (Please specify O2 Type, Liters Flow, O2 Company and Contact Information): _____
- ☐ Other (Please specify O2 Type, Liters Flow, O2 Company and Contact Information): _____

Requires medical equipment that is not easily transportable:

- ☐ Ventilator
- ☐ Suction machine
- ☐ Catheters
- ☐ Feeding Tube
- ☐ Oxygen Concentrator
- ☐ Other equipment (Please Specify):_____

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Required Assistance

This information will be helpful in determining the assistance that the person requires.

1. Are ALL of the support needs resulting in the need for evacuation assistance temporary? (Example: The individual is bedridden due to pregnancy difficulties, but is expected to be fully recovered after the baby is delivered.)
   Check One: ☐ Yes ☐ No, the condition(s) are expected to be permanent.

   Please provide an estimated date when the condition will be resolved

   Month: _____ Year:_____

2. Is the person in need a seasonal resident? ☐ Yes ☐ No

   Date From:_____ **Date To:**_____

3. Does the person in need require evacuation assistance 24 hours a day?

   Check One: ☐ Yes ☐ No

   If you do **not** require evacuation assistance 24 hours a day, when do you need help?

   (Enter time below.)

   Time From:_____ ☐ a.m. ☐ p.m. **Time To:**_____ ☐ a.m. ☐ p.m.

4. Does the person in need have a 24 hour caregiver? ☐ Yes ☐ No

   Will the caregiver travel and stay with you? ☐ Yes ☐ No

Service Animals/Pets:

Please list any Service Animals / Pets in your care that will also require assistance.

According to Florida Statute 413.08 a "service animal" means an animal that is trained to perform tasks for an individual with a disability. The tasks may include, but are not limited to, guiding a person who is visually impaired or blind, alerting a person who is deaf or hard of hearing, pulling a wheelchair, assisting with mobility or balance, alerting and protecting a person who is having a seizure, retrieving objects, or performing other special tasks. A service animal is not a pet..

Service Animal Y/N	Name	Type	Breed / Description	Weight	Carrier Cage? Y/N	Leash? Y/N	Muzzle? Y/N

Additional Comments/Information

Please enter any additional information (e.g.: medical conditions, medications, allergies, etc) that may be useful for our emergency personnel who will be assisting you during an evacuation.

Thank you for completing your special needs survey. The information you provided will be of great value in helping emergency responders plan for the safety of the individuals with special needs in our community. It is crucial to our response efforts that the information you provide be as accurate and up to date as possible. You will be emailed periodically to verify and ensure the information provided is correct and to make any necessary changes. Individual surveys will be archived after one year if not verified.

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By signing this form I give my authorization for medical information contained herein to be released to the Florida Department of Health, State and County emergency management agencies, and receiving facilities for the purpose of evaluating my needs and providing emergency transportation and sheltering. Records relating to registration of disabled citizens are exempt from the provisions of F.S. 119.07 (1), Public Records Law. The information contained here will be kept confidential.

Signature of Applicant: _____ Date: _____

Printed Name: _____

Receiving Agency: _____ Date: _____

Received By: _____