SPECIAL NEEDS REGISTRATION FORM[1]

In accordance with Louisiana State Statute, registration is for residents who have a physical, mental or sensory disability and require assistance with evacuation during an emergency. Registration does not guarantee availability of medical treatment in the shelter. *SSN is requested but not mandatory; the SSN is used to identify registrants.

TRANSPORTATION AND SHELTERING WILL BE PROVIDED BY STATE

Name:_____Sex:____*SSN:_____DOB:_____
Last First MI mm / dd / yy

Phone: (_____)_____Alternate Phone:(_____)_____

Home Address:_____Number of People to Shelter:_____

Mailing Address:_____Number of People to Transport:_____

City:_____Zip Code:_____Subdivision:_____

Name of Apartment Complex/Mobile Home Park:_____Apartment/Lot Number:_____

Nearest major intersection or cross street:_____

	Yes	No		Yes	No
Do you live in a Mobile Home?	{ }	{ }	**Do you have pets?**	{ }	{ }
Do you live in an Evacuation Zone?	{ }	{ }	**Do you have pets?**	{ }	{ }
Will you be accompanied by a caregiver?	{ }	{ }	**Do you have pets?**	{ }	{ }

Contact Information	**Name**	**Phone Number**
Caregiver		
Relative or Friend (Local)		
Relative or Friend (National)		
Physician		
Home Health Care Agency		
Oxygen Provider		

PLEASE CHECK ALL BOXES THAT ARE APPLICABLE (Attach Medical Needs Documentation Separately)

{ }Bedridden – Can you be moved in wheelchair: { }Yes { }No { }Wheelchair Bound { }Walker/Cane

{ }Oxygen: Hours per day:_____ Liter Flow:_____ Portable Tank { } Nebulizer { } Respirator { }

{ }Diabetic (Insulin) { }Diabetic (Non-Insulin) { }Visually Impaired { }Hearing Impaired { }Wound Care

{ }Dialysis { }Cardiac History { }Blood Pressure { }Allergies { }Life Support Equipment(List Type Below)

Additional Medical Condition/Health Needs/Equipment Required:_____

I understand the limitation on the services and level of care available. I grant permission to medical providers, transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs. All assignments will be made on the basis of medical need and available space at the time of evacuation. This registration is voluntary and I hereby request registration in the Specials Needs Program.

Registrant's Signature:_____Date:_____

Completed By:_____Agency:_____

OFFICE USE ONLY:

Does Individual's Care Requirements Exceed Special Needs Shelter Capabilities? { }Yes { }No

DESIGNATED SHELTER:_____EVAC ZONE:_____EVAC PRIORITY:_____

TRANSPORTATION ASSIGNED: NONE SCHOOL BUS /COACH WHEELCHAIR VAN AMBULANCE

[1] Revised May 21, 2008 All previous editions are obsolete