Polk County Special Needs
Emergency Operations Center
1890 Jim Keene Blvd.
Winter Haven, Florida 33880
Phone: 863-298-7027
Fax: 863-298-7172
Email: specialneeds@polk-county.net

SPECIAL NEEDS REGISTRATION FORM

INDIVIDUAL INFORMATION

Last Name: ________________ First Name: ________________________ MI: _____________

Date of Birth: ____________ Gender: __________Full Time Resident: Yes______ No______

Email Address: ____________________________________ Height: _______ Weight: _______

Primary Phone: ________________________ Alternate Phone: ___________________________

Street Number: _________ Street: ______________________ City: _____________ ZIP: _______

Unit/Lot #: _______________ Mailing Address (if different) _________________________________

Mobile Home: YES ____ NO _____ Park Name: _____________________________________

Caregiver: ____

Lives Alone: YES ____ NO ____ Emergency Contact: ________________Phone: _____________

Primary Language: ____________________________________ Pets: YES ____ NO ____

Pet Shelter Arranged: YES ____ NO ____ Service Animal: YES ____ NO ____

MEDICAL INFORMATION

Stroke: YES ____ NO ____ Diabetic: YES ____ NO ____

Cognitive Impairment: YES ____ NO ____ If yes, what? _______________________________

Wound Care: YES ____ NO ____ Cancer: YES ____ NO ____ Incontinent: YES ____ NO ____

Visually Impaired: YES ____ NO ____ Heart Disease: YES ____ NO ____

Dialysis: YES ____ NO ____ Contagious Disease: YES ____ NO ____

Hearing Impaired: YES ____ NO ____

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: YES ____ NO ____ Nebulizer: YES ____ NO ____

Concentrator: YES ____ NO ____ Portable Tank: YES ____ NO ____

Hours Per Day: ______________________ Liter Flow: _____________________

SPECIAL CIRCUMSTANCES

Bedridden: YES ____ NO ____ Ventilator: YES ____ NO ____

Assistance with medication: YES ____ NO ____ Combative/Violent: YES ____ NO ____

Continuous Equipment: YES ____ NO ____ Wheelchair: YES ____ NO ____

Electric Wheelchair: YES ____ NO ____ Hoyer Lift: YES ____ NO ____

Walker: YES ____ NO ____

TRANSPORTATION

Transportation required: YES ____ NO ____ Transportation Only: YES ____ NO ____

Ambulance: YES ____ NO ____ Wheelchair Lift: YES ____ NO ____

Stretcher: YES ____ NO ____ How many steps to front door? ___________________

SHELTER ASSIGNMENT (to be completed by special needs personnel)

Shelter: ____________________________ Transportation: __________________

Updated 4/11/2019