

**PLEASE PRINT**

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

FOR EMERGENCY MANAGEMENT USE ONLY  
 Fire District \_\_\_\_\_ Shelter Type: General / SPNS  
 Date Entered \_\_\_\_\_ Entered By \_\_\_\_\_

Date: \_\_\_\_\_

**SPECIAL NEEDS PROGRAM PERSONAL INFORMATION**

Will you be going to a shelter if evacuated?  Yes  No  
 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)

Name: \_\_\_\_\_ Spouse: \_\_\_\_\_

Address: \_\_\_\_\_ Apt/Lot #: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Do you live in a mobile home?  Complex Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male:  Female:  SSN: \_\_\_\_\_

Are you legally blind:  Yes  No (Hearing impaired:  Yes  No) Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Primary Language: \_\_\_\_\_

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

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**List Your Medications**

Name	Strength	Name	Strength

**Check all that apply:**

<input type="checkbox"/> Bedridden	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Walker/Cane	<input type="checkbox"/> Crutches
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Insulin	<input type="checkbox"/> IV	<input type="checkbox"/> Trained Service Animal
<input type="checkbox"/> Mental Health Problems	<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Dementia	<input type="checkbox"/> Obsessive Compulsive Disorder
<input type="checkbox"/> Autism	<input type="checkbox"/> Conduct Disorder	<input type="checkbox"/> Anxiety or Depression	<input type="checkbox"/> Incontinence
<input type="checkbox"/> CPAP	<input type="checkbox"/> Nebulizer	<input type="checkbox"/> Feeding Pump	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Oxygen	No. of hrs. needed daily _____	Liter flow _____	Portable tank _____

General Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Home Health/Hospice Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Dialysis Center Location: \_\_\_\_\_

Medical Equipment Provider: \_\_\_\_\_

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: \_\_\_\_\_