



Seminole County's Office of Emergency Management

VOLUNTARY MEDICALLY ENHANCED SHELTER/WELL CHECK PROGRAM REGISTRATION FORM

(This form must be filled out completely. Please print clearly)

By signing up for the Voluntary Medically Enhanced Shelter/Well Check Program, you are acknowledging that you have read, understood, and agree with the Notice of Privacy Practices for Protected Health Information.

ASSISTANCE REQUESTED			
<input type="checkbox"/> Evacuation/Transportation (Assistance evacuating to a Medically Enhanced Shelter due to a medical condition)			
<input type="checkbox"/> Wellness Check (Have someone contact you after an emergency or disaster)			
PERSONAL INFORMATION			
Last Name:	First Name:	Birth Date: ____/____/____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F Primary Language: _____
Address:		Apartment/Unit#:	
City:	Zip:	Name of Complex/Subdivision:	
Type of Residence: <input type="checkbox"/> Single Family Home <input type="checkbox"/> Apartment/Condo <input type="checkbox"/> Mobile Home/Manufactured Home			
Home Phone: _____ Mobile Phone: _____ Other Phone: _____			
E-Mail Address: _____			
EMERGENCY INFORMATION			
Living Status: <input type="checkbox"/> Alone <input type="checkbox"/> With Relative <input type="checkbox"/> With Caregiver <input type="checkbox"/> Other (please indicate) _____			
Local Emergency Contact Name:		Local Emergency Contact Phone:	
Non-Local Emergency Contact Name:		Non-Local Emergency Contact Phone:	
Will you have a companion/caretaker accompanying you to the evacuation location? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, Companion Name: _____ Companion Phone: _____			
CLIENT INFORMATION			
Do you use oxygen?		<input type="checkbox"/> Yes (<input type="checkbox"/> Intermittent <input type="checkbox"/> Continuous) <input type="checkbox"/> No	
• If yes, Oxygen Provider: _____ Phone: _____			
Do you use medical equipment that requires electricity to operate?		<input type="checkbox"/> Yes (<input type="checkbox"/> Intermittent <input type="checkbox"/> Continuous) <input type="checkbox"/> No	
• If yes, specify the equipment that requires electricity: _____			
Do you use medication that requires refrigeration?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use an LVAD (Left Ventricular Assistive Device)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you receive dialysis?		<input type="checkbox"/> Yes (<input type="checkbox"/> At Home <input type="checkbox"/> At Facility) <input type="checkbox"/> No	
Are you confined to a bed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you require a Hoyer lift to transfer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you utilize a service animal?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have pets?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use a wheelchair?		<input type="checkbox"/> Yes (<input type="checkbox"/> Electric <input type="checkbox"/> Manual) <input type="checkbox"/> No	
Do you require transportation to a shelter?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
• If yes, do you require ADA / Wheelchair Lift?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
OFFICE USE ONLY			
<input type="checkbox"/> SpNS Shelter		<input type="checkbox"/> Well Check	<input type="checkbox"/> Beyond Care
Reviewer Signature: _____		Date: _____	

By signing up for the Voluntary Medically Enhanced Shelter/Well Check Program, you are acknowledging that you have read, understood, and agree with the Notice of Privacy Practices for Protected Health Information.