

ST. JOHNS COUNTY EVACUATION ASSISTANCE REGISTRATION FORM



St. Johns County Emergency Management | 100 EOC Drive | St. Augustine, FL 32092
Phone (904) 824-5550 | Fax (904) 824-9920
Online Registration: www.sjcemergencymanagement.org

The Evacuation Assistance Program is for any citizen of St. Johns County who needs assistance during a disaster situation requiring evacuation to a Public Shelter or a Special Needs Shelter. A Special Needs Shelter is capable of providing **limited** medical care only. If you require ambulance transportation and / or hospital facilities you or your care-giver should make those arrangements ahead of time. Shelters should be your refuge of last resort if you have absolutely no where else to go.

Residents of nursing homes, convalescent homes, retirement homes, assisted living facilities, or other group facilities, will look to the management of their facility for an organized group evacuation. Under Florida State Statute 252 it is required these facilities have an Emergency Plan to evacuate their residents to a predetermined location outside the evacuation area.

All records, data, information, and correspondence relating to the registrants of the Evacuation Assistance Program are confidential and exempt from disclosure and can be made available only to other emergency response agencies (Section 252.355, Florida State Statute).

This form must be completed in full or it will be returned to you. Please print clearly.

PERSONAL INFORMATION:

New Registrant: Yes No Registrant Update: Yes No Today's Date: _____

Last Name: _____ First Name: _____ MI: _____ Sex: M ___ F ___

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ lbs.

Physical Address: _____
Street City Zip

Mailing Address: _____
Street / Post Office Box City Zip

Telephone Number: _____ / _____
Area Code / Phone Number Alternate Number (cell phone, etc.)

Primary Language: _____ Secondary Language: _____

Living Situation: Alone w/Spouse w/Parents w/Children w/Other _____

Residence Type: House/Duplex Mobile Home/RV Apartment/Condo

EMERGENCY CONTACT INFORMATION: (List all that apply)

(Caregiver) Name: _____ Relationship: _____ Phone: _____

(Local) Name: _____ Relationship: _____ Phone: _____

(Non-Local) Name: _____ Relationship: _____ Phone: _____

Receiving home health care: No Yes Agency: _____ Phone: _____

Receiving hospice care: No Yes Agency: _____ Phone: _____

No Medical Needs – Need Transportation Only

MEDICAL INFORMATION: (List all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Alzheimer’s Disease | <input type="checkbox"/> Dementia | <input type="checkbox"/> Senility |
| <input type="checkbox"/> Anxiety / Depression | <input type="checkbox"/> Mental Health Impaired | <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> Blind | <input type="checkbox"/> Deaf | <input type="checkbox"/> Speech Impaired |
| <input type="checkbox"/> Guide/Service Animal | Service Animal Type: _____ | |
| <input type="checkbox"/> Mobility Impaired | <input type="checkbox"/> Cane/Walker | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Bedridden | Could sleep on cot/air mattress in disaster situation: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> VAD System / LVAS System |
| <input type="checkbox"/> Diabetic Diet | <input type="checkbox"/> Insulin Dependent | <input type="checkbox"/> Dialysis Dependent |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Bladder <input type="checkbox"/> Bowel | ↳ times per week _____ |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Parkinson’s Disease | |
| <input type="checkbox"/> Catheter Line | <input type="checkbox"/> Intravenous Line | <input type="checkbox"/> Feeding Tube |
| <input type="checkbox"/> Ostomy Care | <input type="checkbox"/> Ileostomy | <input type="checkbox"/> Colostomy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Nebulizer | <input type="checkbox"/> COPD |
| | | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> BiPAP | <input type="checkbox"/> CPAP |
| <input type="checkbox"/> Oxygen Dependent | <input type="checkbox"/> Intermittent Use | <input type="checkbox"/> Continuous Use |
| ↳ type of oxygen used | <input type="checkbox"/> Tank | <input type="checkbox"/> Concentrator |

Allergies: _____

Medications: _____

TRANSPORTATION INFORMATION: (List all that apply)

- Can you drive yourself to a Shelter: Yes No
- Can someone drive you to a Shelter: Yes No
- Is someone going to the shelter with you: Yes No Who: _____

If no, check the type of transportation you need us to provide:
 Car / Bus Wheelchair Van Stretcher Van Other: _____

Do you have Pets: No Yes If yes, type and number of animals: _____

Person Completing Form: _____ **Relationship:** _____

This Section is to be Completed by Emergency Management		
Shelter Status:	Public <input type="checkbox"/>	Public Pet <input type="checkbox"/> Special Needs <input type="checkbox"/>
	Can't Support <input type="checkbox"/>	No Need <input type="checkbox"/>
Transport:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Evac Zone: _____ Fire Zone: _____
Date Received:	_____	Date Notified: _____ Date Removed: _____