EVACUATION CHECKLIST
FOR SPECIAL NEEDS EVACUEES

Listed below are actions you should take **BEFORE** evacuations. You and your caregiver **MUST** be ready before your county evacuation transportation vehicle arrives. Special Needs evacuations need to be completed prior to road congestion. Even if the sun is shining, the storm is on its way!! Osceola County Emergency Management, Osceola County Health Department and/or Osceola County Council on Aging will call to give you an estimated time of your transportation pick-up.

HERE ARE SOME THINGS YOU SHOULD DO BEFORE BEING PICKED UP:

WHEN EVACUATING:

1. Pack a bag and be ready to go with:
   - Medications for 3 weeks, list of medications, Pharmacy name & number, Doctors' name & number, your walker, wheelchair and other medical equipment
   - If oxygen dependent, bring all equipment. Emergency oxygen will be provided.
   - Clean clothes for three days
   - Extra eye glasses & flashlight
   - Blankets and pillows, sheet if desired for cot
   - Personal hygiene items, towel & wash cloth
   - House keys and car keys
   - Personal phone book or list of important numbers
   - Important papers, including identification, sealed in zip-lock bags
   - Folding chair or lawn chair
   - Reading materials
   - Non-perishable snack items, bottle of water while shelter becomes fully operational
   - Non-perishable food items if you require a special diet
   - Medical orders including “Do Not Resuscitate” order, if applicable.

2. Call caretaker and family members including those out of state, to inform them of your evacuation plans.

3. It is important to turn off electricity, water and gas if possible. Be sure to follow turn off instructions given by your utility company.

WHEN STORM IS APPROACHING:

1. Take care of all medical needs such as dialysis when you hear a storm is approaching.

OSCEOLA COUNTY SPECIAL NEEDS SHELTER APPLICATION
2013

DATE:_____

PLEASE COMPLETE ALL AREAS ON BOTH PAGES (PRINT)

LAST NAME:	**FIRST NAME:**		**MI:**
STREET ADDRESS:			**APT/LOT #**
CITY:	**ZIP:**	**PHONE:**	
COMMUNITY/SUBDIVISION NAME:	**MALE** ☐ **FEMALE** ☐	**IS THIS A MOBILE HOME? YES ___ NO ___**	
DATE OF BIRTH:	**AGE:**	**HEIGHT:**	**WEIGHT IN LBS:**
LIVING SITUATION: (CHECK ONE) ___ ALONE ___ SPOUSE ___ CHILDREN ___ PARENTS ___ OTHERS			

NOT LIVING WITH YOU - NAME OF FAMILY OR FRIEND IN CASE OF EMERGENCY

NAME: _____ PHONE: _____

RELATIONSHIP TO YOU? _____

SPEAK ENGLISH: YES ___ NO ___ IF NO WHAT LANGUAGE? _____

WILL YOU BE ACCOMPANIED TO THE SHELTER BY A CAREGIVER? YES ___ NO ___

CAREGIVER'S NAME: _____ PHONE: _____

RELATIONSHIP: _____ AGE: _____ MALE: ___ FEMALE: ___

DO YOU HAVE TRANSPORTATION TO THE SPECIAL NEEDS SHELTER? YES ___ NO ___

IF TRANSPORTATION IS NEEDED, CAN YOU HANDLE STEPS ON A BUS? YES ___ NO ___

IF NOT, WILL YOU NEED A WHEELCHAIR LIFT? YES ___ NO ___

HOME HEALTH AGENCY: _____ PHONE: _____

PHYSICIAN: _____ PHONE: _____

OXYGEN & MED. SUPPLY COMPANY: _____ PHONE: _____

PHARMACY_____ PHONE: _____

OSCEOLA COUNTY SPECIAL NEEDS SHELTER APPLICATION
2015

NAME: _____ **DATE:** _____

PLEASE TELL US ABOUT YOUR MEDICAL CONDITION - CHECK ALL THAT APPLY:

☐ OXYGEN DEPENDENT	☐ DIABETIC	☐ PARKINSON'S
☐ PORTABLE TANK	☐ INSULIN DEPENDENT	☐ SEIZURES _____
☐ NEBULIZER	WALKING	☐ DIALYSIS
☐ CPAP MACHINE	MOBILE YES ☐ NO ☐	☐ DAYS OF TX: M T W Th F S
☐ ASTHMA	☐ FALLS	AGENCY NAME:
☐ OTHER _____	☐ CANE	☐ ANEMIA
☐ CARDIAC CONDITION	☐ WALKER	☐ HEARING IMPAIRED
☐ HIGH BLOOD PRESSURE	☐ WHEELCHAIR/SCOOTER	☐ LIMITED VISION
☐ PACEMAKER	☐ OTHER _____	☐ BLIND
☐ HISTORY OF STROKE	☐ ARTHRITIS	☐ HELP NEEDED WITH MEDS?
☐ PARTIAL PARALYSIS	☐ CANCER	☐ INCONTINENCE
☐ DETAILS _____	☐ CURRENT TX. _____	☐ INDWELLING CATHETER
☐ ANXIETY/DEPRESSION	☐ ALZHEIMER/DEMENTIA	☐ COLOSTOMY OR ILEOSTOMY

DETAILS ON MEDICAL CONDITION: _____

LIST ALLERGIES: _____

SPECIAL DIETARY NEEDS: _____ **LIST FOOD ALLERGIES:** _____

CURRENT MEDICATIONS

1)_____	4)_____	7)_____
2)_____	5)_____	8)_____
3)_____	6)_____	9)_____

PETS YES ____ NO ____ # OF CATS _____ # OF DOGS _____ OTHER _____

I AGREE THAT MY NAME MAY BE ADDED TO THE SPECIAL NEEDS SHELTER LIST. I GIVE OSCEOLA COUNTY EMERGENCY MANAGEMENT AUTHORITY TO SHARE THIS INFORMATION WITH OTHER AGENCIES IN THE EVENT OF AN EMERGENCY EVACUATION. I UNDERSTAND THAT BY SIGNING THIS FORM, I GRANT EMERGENCY RESPONDERS PERMISSION TO ENTER MY HOME AT THE TIME OF AN EMERGENCY. I UNDERSTAND THE LIMITATION ON THE SERVICES AND LEVEL OF CARE AVAILABLE.

SIGNED: _____ **DATE:** _____

NOTE: THIS FORM MUST BE SIGNED BY THE SPECIAL NEEDS CLIENT OR AUTHORIZED AGENT!

IF AUTHORIZED AGENT: NAME: _____ **PHONE:** _____

RELATIONSHIP TO CLIENT: _____

PERSON COMPLETING FORM (PRINT): _____

OSCEOLA COUNTY ANNUAL SPECIAL NEEDS SHELTER APPLICATION

There are several shelter options that will be used in the event of an emergency:

1) REGULAR SHELTERS are for residents who are able to perform normal activities of daily living and can manage their own medical care.
THERE IS NO NEED TO APPLY FOR SPACE IN A REGULAR SHELTER.

2) SPECIAL NEEDS SHELTER
YOU MAY BE ELIGIBLE FOR A SPECIAL NEEDS SHELTER IF YOU REQUIRE ASSISTANCE WITH ACTIVITIES OF DAILY LIVING. SOME EXAMPLES:

- ✓ **YOU NEED SOME ASSISTANCE WITH THE ADMINISTRATION OF MEDICINES**
- ✓ **YOU ARE OXYGEN OR ARE ELECTRICITY DEPENDANT**
- ✓ **YOU SUFFER FROM EMPHYSEMA, PARTIAL PARALYSIS, HEART PROBLEMS, PARKINSON'S DISEASE, DEMENTIA OR INCONTINENCE.**

IT IS REQUIRED TO APPLY FOR A SPECIAL NEEDS SHELTER ANNUALLY.

3) HOSPITAL ADMITTANCE
If you suffer from an unstable medical condition or are receiving on-going treatment, then a Special Needs Shelter MAY NOT meet your needs. YOU MUST TALK TO YOUR DOCTOR NOW ABOUT BEING ADMITTED TO A HOSPITAL DURING AN EMERGENCY. THIS INCLUDES LATE TERM PREGNANCY AND OTHER UNSTABLE CONDITIONS.

NOTE:

- < ***SPECIAL NEEDS SHELTERS ARE FOR CLIENTS AND THEIR DESIGNATED CARE GIVER ONLY. EFFORTS WILL BE MADE TO ACCOMMODATE REGULAR FAMILY MEMBERS IN A REGULAR SHELTER.***
- < ***APPLICATION DOES NOT AUTOMATICALLY GUARANTEE ASSIGNMENT; THE ASSIGNED TRIAGE MEDICAL ADVISOR AT THE SHELTER WILL MAKE THE FINAL DETERMINATION.***
- < ***CLIENTS MUST PROVIDE THEIR OWN MEDICATION, MEDICAL EQUIPMENT AND AT LEAST 24 HOURS OF OXYGEN. CURRENT MEDICAL INFORMATION WILL BE REQUIRED.***
- < ***PETS ARE NOT ALLOWED IN A SPECIAL NEEDS SHELTER. IF YOU ARE UNABLE TO MAKE PRIVATE ARRANGEMENTS FOR YOUR PETS, LET US KNOW. TRANSPORTATION WILL BE PROVIDED TO TAKE THEM TO A PET SHELTER. YOU WILL NEED TO HAVE YOUR ANIMAL'S VACCINATION RECORDS AVAILABLE.***
- < ***ONCE YOU HAVE BEEN ACCEPTED, YOU WILL BE PROVIDED WITH A LIST OF THE ITEMS YOU NEED TO BRING TO THE SPECIAL NEEDS SHELTER.***

Please complete the attached forms and return immediately.

PLEASE RETURN YOUR SPECIAL NEEDS REGISTRATION FORM TO:
OSCEOLA COUNTY HEALTH DEPARTMENT
ATTENTION: SPECIAL NEEDS REGISTRATION
1875 FORTUNE ROAD
KISSIMMEE, FL 34744
(407) 343-2133