



Hillsborough County Health Department Shelter Evaluation Form **(PLEASE PRINT)**

Failure to complete the entire form WILL delay your evaluation!

Last Name: _____ First Name: _____ SSN: _____

Sex: Male Female Weight: _____ Date of Birth: _____ Phone: _____

Street Address: _____ Lot/Apt #: _____

City: _____ Zip Code: _____ Do you live in a mobile home? Yes No

Apartment Complex or Mobile Home Park Name (If applicable) _____

Mailing Address (if different): _____

Local Emergency Contact Name: _____ Phone #: _____

Name of a relative/neighbor/manager that can check your residence after a storm:

Name: _____ Phone #: _____

Who will be coming to the shelter with you? _____ Phone #: _____

Doctor's Name: _____ Phone #: _____

Why do you need to come to the shelter? _____

- Do you need a ride to the shelter? Yes No
- Can you get out of bed? Yes No
- Do you normally use a wheelchair? Yes No
- Do you normally use a walker? Yes No
- Do you have a guide dog or other service animal? Yes No
- Do you regularly use medical equipment? Yes No If Yes, what: _____
- Do you require Oxygen? Yes No If Yes, Oxygen Provider: _____
- Do you require Dialysis? Yes No If Yes, Dialysis Provider: _____
- Are you on a Ventilator? Yes No
- Who helped you complete this form? _____

*****Please allow 2-3 weeks for processing and shelter assignment notification.*****

I understand the limitation on the services and level of care available at a Special Needs Shelter. I grant permission to medical providers, transportation agencies, and others as necessary, to provide care and disclose any information necessary to respond to my needs. I understand that registration does not guarantee assignment to the special needs shelter. All assignments will be made on the basis of medical need and available space at the time of evacuation. **I understand that, if I am assigned to a special need shelter, I am limited to one person to accompany me to the shelter.** This registration is voluntary and I hereby request registration in the Special Needs Program.

Signature of Patient / Guardian

Date Signed

For Office Use Only (Check all that apply):

Special Needs Shelter: _____ Red Cross Shelter: _____ Hospital: _____ Shriners: _____ Dialysis: _____ FAHA _____ Aging Services _____



**Return form to: Hillsborough County Health Department PO Box 5135 Tampa, FL 33675-5135
Or FAX to (813) 276-8689. For more information call (813) 307-8015 Ext. 6006.**