EMERGENCY CONTACT INFORMATION:

First Name	Last Name	Address:	Phone:

PHYSICICAN/PHARMACY INFORMATION:

Physician's Last Name:	First Name:	Phone:

Pharmacy Name/Location:	Phone:

Home Health Care Agency:	Phone:

Please list all medications: _____
_____
_____
_____

SHELTER INFORMATION:

Method of Transportation:
{ } Self { } Stretcher { } Van with wheelchair lift
{ } Non-Emergency Transportation (*patient must initial*)
_____
{ } Other:_____

Alternate Person:_____

PET INFORMATION:

(If applicable, indicate how many)

_____ Cat _____ Other:

_____Dog

_____ Service Dog

Name of person going with patient to the shelter:
_____
Relationship to patient:
_____

Phone:

COMMENT:

AUTHORIZATION INFORMATION:

I agree that my name be added to the Accessible Shelter Emergency List. I give Muscogee County Emergency Management, Contact Chattahoochee Valley, Inc, and/or Mayor's Committee for Persons with Disabilities authorization to share this information with other local support agencies in the event of an emergency evacuation. I also grant emergency response personnel permission to enter my home during search and rescue operations following a disaster, if necessary, to assure my safety and welfare.

Patient Signature: _____ Date: _____

Authorized Signature: _____ Date: _____

Relationship to Patient: _____ Date: _____

Forward Form to: CONTACT Chattahoochee Valley, Inc., P.O. Box 5414, Columbus, GA 31906. FAX: 706-322-2877.
For more information, contact the Mayor's Committee for Persons with Disabilities at: 706-225-3632 (Phone); 706-225-3633 (Fax); 706-225-3629 TDD. Address: P.O. Box 1340, Columbus, GA 31902-1340.

OFFICIAL USE ONLY:

_____ Special Needs Shelter This application screened by: _____
Print Name/Dept.

_____ Congregant Shelter

EMERGENCY PREPAREDNESS ACCESSIBLE SHELTER INFORMATION

Personal Information: **New Application: _____**
Application Update: _____

Last Name:	First Name:	MI.	Date of Birth:	Sex: _____ Weight: _____
Street Address:	City:		Zip:	Phone:
Mailing Address (*if different)*	City:		Zip:	Mobile Home? { }Yes { } No
Name of Subdivision, MH Park, Apt Bldg., etc.:	Flood Prone Area? { } Yes { } No		Primary Language:	

Living Situation: (*check one)* { } Lives Alone { } With Spouse { } With Children { } With Parents

Other: (*Explain)*

MEDICAL INFORMATION: *(Check and complete those that apply to your medical condition.)*

{ } Required or Life-Sustaining Medical Equipment
{ } Oxygen Concentrator { } Respirator (Ventilator)
{ } Portable Oxygen { } Suction Machine
{ } Nebulizer { } Other _____

{ } Oxygen – Continuous
Amount of Oxygen? _____
{ } Treatments Only
Amount of Oxygen? _____
How often? _____
{ }Oxygen –PRN (As Needed)
Night time- # of hours? _____
Day time- # of hours? _____
Amount used per day? _____

Name of oxygen company/supplier _____
Phone number of oxygen company/supplier _____

{ }Cardiac History
{ }Dialysis How often? _____
{ } Incontinent
{ } Life-Sustaining Medications
{ } Frail
{ } Mobility Impaired (*explain)*_____

_____

{ }Wheelchair Bound
{ } Walker
{ } Bedridden
{ } Hearing Impaired
Sign Language: _____
{ } Sight Impaired
{ } Seizures
*(Explain)*_____

{ }Speech Impaired
{ } Memory Impaired (Explain)
_____
{ }Anxiety/Depression
{ } Colostomy or Ileostomy
{ } Stroke
{ } G-tude Feeders
{ } Emergency Alert Equipment
{ } DNR Order (*if so, attach copy)*
{ } Mental Health Impaired
*(Explain)*_____
{ } Special Dietary Needs (*explain)*
_____
{ } Allergies (*list)*
_____
{ } Other

Primary Diagnosis:	Secondary Diagnosis:	If Disability is temporary, give dates: From: _____ To: _____