Florida Special Needs Registry
Registration Information - Duval County

Instructions: Complete this form and fax or mail it to Duval County to register an individual for the Florida Special Needs Registry. This form is not required if you have already registered online. Required fields are indicated with an asterisk (*).

Mail: Duval County Special Needs Registry
515 North Julia St
Jacksonville, FL 32202

Fax: (904) 376-8915

PERSONAL INFORMATION ABOUT THE REGISTRANT			
*First Name		*Last Name	
*Birth Date		*Primary Language	
*Registrant Phone Number		*Phone Type	☐Home ☐Cell
*Email			
*Gender (select only one)	☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Prefer Not To Provide		
Height Feet: Inches: ☐ Unable to Verify	Weight lbs ☐ Unable to Verify	*Pet: ☐ Yes ☐ No	Service Animal ☐ Yes ☐ No
Are you completing this form on behalf of the registrant? If so, please indicate your relationship to the registrant (select only one)	☐ Family Member ☐ Caregiver ☐ Neighbor ☐ Friend ☐ Health Care Provider ☐ County Emergency Management Staff ☐ County Health Department Staff ☐ DOH State Staff		

REGISTRANT'S EQUIPMENT	
Electrical Dependency Needs: (select all that apply)	☐ Apnea Monitor ☐ Feeding Pump ☐ Suction Pump ☐ Trilogy ☐ Ventilator ☐ CPAP / BiPAP ☐ Dialysis Catheter ☐ Nebulizer ☐ Wound Vac ☐ Cardiac Monitor ☐ Oxygen Concentrator ☐ Medication that requires refrigeration ☐ Other:

EMERGENCY CONTACT FOR THE REGISTRANT (required)			
*Primary Emergency Contact Name		*Relationship	
*Contact Primary Phone Number	Ext:	Phone Type	☐Home ☐Cell
*Secondary Emergency Contact Name		*Relationship	
*Contact Primary Phone Number	Ext:	Phone Type	☐Home ☐Cell

ADDRESS FOR THE REGISTRANT (physical address is required)					
*Physical Address (cannot be a PO Box)					
Apt #, Unit #, Bldg #, Suite #, etc.					
*Physical City		*Physical State	FL	*Physical Zip Code	

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TRANSPORTATION & MOBILITY	
Registrant has the following transportation needs: (select all that apply)	☐ Jacksonville Transportation Authority ☐ Wheelchair Accessible Vehicle ☐ Ambulance
Registrant has the following mobility issues: (select all that apply)	☐ Is confined to a bed ☐ Is paralyzed (complete or partial) ☐ Uses a Hoyer Lift ☐ Uses a Cane ☐ Uses a Walker ☐ Uses a Motorized Wheelchair/ Scooter

MEDICAL & OTHER			
Memory: (select all that apply) (Caregiver required for memory impaired clients)	☐ Alzheimer and related dementia ☐ Dementia ☐ Memory Impaired		
Mental or Behavioral: (select all that apply)	☐ Anxiety ☐ Bipolar ☐ Flight risk ☐ Psychosis ☐ Personality Disorder ☐ Obsessive/Compulsive ☐ Substance Abuse ☐ Conduct Disorder ☐ Combative/Violent ☐ Schizophrenia ☐ Self-injurious or danger to others ☐ Autism/Developmental Delay ☐ Other		
Dialysis Dependent:	☐ Yes ☐ No	**Oxygen Dependent:**	☐ Yes ☐ No
Other Medical Conditions: (select all that apply)	☐ Vision Impaired ☐ Hearing Impaired ☐ Speech Impaired ☐ Incontinent ☐ Seizures ☐ Foley Catheter ☐ Diabetic ☐ Open/Healing Wound ☐ Pacemaker ☐ Colostomy/Ileostomy ☐ Other		