# Florida Special Needs Registry
# Registration Information - Duval County

Instructions: Complete this form and email 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

Email: specialmedicalneeds@coj.net

| 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 ☐ DOH State Staff<br>☐ County Emergency Management Staff ☐ County Health Department Staff<br>☐ Health Care Provider _____<br>Health Care Provider Name here | | | | | | |
| **Do you have a caregiver that will be with you?** | ☐ Yes ☐ No | | | | | | |

| REGISTRANT'S EQUIPMENT | |
|---|---|
| **Electrical Dependency Needs (select all that apply)** | ☐ Apnea Monitor ☐ Feeding Pump ☐ Suction Pump<br>☐ Trilogy ☐ Ventilator ☐ CPAP / BiPAP ☐ Dialysis Catheter<br>☐ Nebulizer ☐ Wound Vac ☐ Cardiac Monitor<br>☐ Oxygen Concentrator ☐ Medication that requires refrigeration<br>☐ 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<br>☐ Wheelchair Accessible Vehicle<br>☐ Ambulance |
| **Registrant has the following mobility issues: (select all that apply)** | ☐ Is confined to a bed ☐ Is paralyzed (complete or partial)<br>☐ Uses a Hoyer Lift ☐ Uses a Cane ☐ Uses a Walker<br>☐ Uses a Motorized Wheelchair/ Scooter |

| MEDICAL & OTHER | | | |
|---|---|---|---|
| **Memory: (select all that apply)**<br>**(Caregiver required for memory impaired clients)** | ☐ Alzheimer and related dementia<br>☐ Dementia<br>☐ Memory Impaired | | |
| **Mental or Behavioral:**<br>**(select all that apply)** | ☐ Anxiety ☐ Bipolar ☐ Flight risk ☐ Psychosis<br>☐ Personality Disorder ☐ Obsessive/Compulsive ☐ Substance Abuse<br>☐ Conduct Disorder ☐ Combative/Violent ☐ Schizophrenia<br>☐ Self-injurious or danger to others ☐ Autism/Developmental Delay<br>☐ Other | | |
| **Dialysis Dependent** | ☐ Yes ☐ No | **Oxygen Dependent** | ☐ Yes ☐ No |
| **Other Medical Conditions:**<br>**(select all that apply)** | ☐ Vision Impaired ☐ Hearing Impaired ☐ Speech Impaired<br>☐ Incontinent ☐ Seizures ☐ Foley Catheter ☐ Colostomy/Ileostomy<br>☐ Type 1 Diabetic ☐ Type 2 Diabetic ☐ Pacemaker<br>☐ Open/Healing Wound ☐ Other | | |
| **Please provide any additional information regarding your medical conditions here:** | | | |

| REQUIRED AUTHORIZATION FOR RELEASE OF REGISTRANT INFORMATION | | | |
|---|---|---|---|
| **How did you hear about the registry?** | | | |
| **Name of Submitter** | | **Relationship to Registrant** | |
| **Signature of Submitter** | | | |

***F.S. 252.355(b) Registry of persons with special needs; notice; registration program.***
*The registration program shall give persons with special needs the option of preauthorizing emergency response personnel to enter their homes during search and rescue operations if necessary to ensure their safety and welfare following disasters.*