CITY OF JACKSONVILLE / DUVAL COUNTY
SPECIAL MEDICAL NEEDS REGISTRATION FORM

Do you plan on using a **Public Shelter** in the event of a disaster? ❑NO ❑YES

If "NO," DO NOT COMPLETE THIS FORM.

If "YES," please complete **ALL** information on both sides of this form and mail it to the return address on the back.

NOTE: REGISTRATION should be UPDATED and submitted ANNUALLY. **PLEASE PRINT INFORMATION**

REQUIRED Personal Enrollment Data (One person per form):

Today's Date: _____

Name: _____ Sex: ❑Male ❑Female

Last First Middle

Address: _____

Street (Including Apartment or Unit Number) City State Zip

***Telephone**: _____ Alt Number/ Email Address: _____

Height: ___ Ft ___in Date of Birth: _____ Age: ____ Wt: ___ Language: _____

Residence Type**:** ❑ House/Duplex ❑ Mobile Home/Trailer ❑ Apartment/Condo

Living Situation**:** ❑ Living Alone ❑ With Parents ❑ With Family ❑ With Non-Relative

Name of Contact in your home: _____ ❑ Pets (non-service animal)

Emergency Contacts:

(Local) Name: _____ Relationship: _____ Phone: _____

(Non-Local) Name: _____ Relationship: _____ Phone: _____

Special Medical Needs (Check all that apply):

- ❑ Medical Dependence on Electricity
  - ❑ Medication requiring refrigeration
  - ❑ Feeding pump
  - ❑ Suction
  - ❑ Other _____
  - ❑ CPAP - BIPAP
- ❑ Medical Dependence on Oxygen
  - ❑ O2 Concentrator
  - ❑ Nebulizer
  - ❑ Respirator Dependent
- ❑ Assistance with administration of Medications, Including Insulin
- ❑ Dialysis Dependent
- ❑ Cognitive Impairment
- ❑ Anxiety/Depression
- ❑ Mental Health Problem
- ❑ Alzheimer's
- ❑ Dementia
- ❑ Developmentally Disabled
- ❑ Psychiatric or Personality Disorder: _____
- ❑ Bedridden
- ❑ Open Wounds/ Decubitus
- ❑ Hospital Preferred: _____
- ❑ Speech Impaired
- ❑ Vision Loss/Impaired
- ❑ Hearing Loss/Impaired
- ❑ Service Animal
- ❑ Incontinence
- ❑ Mobility Impaired
  - ❑ Walker/cane
  - ❑ Wheelchair
  - ❑ Hoyer Lift
- ❑ Morbid Obesity

Assistance Required:

Do you have a caregiver who will be with you? ❑ NO ❑ YES (Caregivers are highly recommended!)

If "Yes," Name: _____ Phone: _____

Do you need transportation to a Special Needs shelter in the event of a disaster? ❑ NO ❑ YES

If "YES," Check One: ❑ JTA Wheelchair Bus ❑ Ambulance: _____ (Name Company)

NOTE: Ambulance Transportation will be provided ONLY for you plus one caregiver.

*** Contact phone number required.**

Please complete back of form (next page).

Other Medical Information:

Other Medical Concerns: _____

_____

Primary Doctor: _____ Telephone: _____

Home Health Agency: _____ Telephone: _____

Pharmacy: _____ Telephone: _____

Dialysis Center Name: _____ Telephone: _____

Health Insurance Provider: _____ Telephone: _____

Home Medical Equipment Provider: _____ Telephone: _____

Allergies: _____

Medications:_____

_____

Consent:

In Case of Emergency, I, _____, authorize rescuers to enter my home.

Printed Name: _____

By signing this form, I, _____, agree that the information stated on this form is accurate and truthful, to the best of my knowledge.

Signature: _____ Date: _____

❑**I do not authorize** ❑**I do authorize** the release of this form in whole or in part to any third party.
Should I fail to make a selection, I do not authorize the release of this form.

Person Completing Form (If different from shelteree): _____
Address/Company: _____ Phone: _____

IMPORTANT NOTES:

- In an actual emergency, response agencies will try to provide the necessary assistance, but this cannot always be assured.
- To best guarantee personal safety, individuals should make plans and follow government emergency response guidance.
- The purpose of Special Medical Needs Shelters is to provide **shelter as a last resort**. A personal caregiver should accompany registered Special Medical Needs individuals to a Special Medical Needs shelter.
- Nursing homes have approved plans for evacuation and sheltering of residents that do not include use of Special Medical Needs Shelters. Contact your nursing home if you have questions or for more information.

All information contained in this form is confidential and exempt from disclosure and can be made available only to other emergency response agencies (Section 252.355, Florida Statute).

MAIL or FAX TO: **Jacksonville Fire & Rescue Department, Emergency Preparedness Division**
515 N. Julia Street, 4th Floor, Jacksonville, Florida 32202

Fax: 904-630-0600 **Phone: 904-255-3110**