

# SPECIAL NEEDS REGISTRATION

## City of Jacksonville/Duval County Special Medical Needs Evacuation Registration

Do you plan on using a Public Shelter in the event of a disaster? NO YES (Circle One)

If "NO," DO NOT COMPLETE THIS FORM. ←

If "YES," please PRINT 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.

### REQUIRED PERSONAL ENROLLMENT DATA

(One Person Per Form)

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Sex: \_\_\_\_\_  
Last First Middle (Select One)

Street Address: \_\_\_\_\_  
Street City Zip

Mailing Address (if different from above) \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Wt: \_\_\_\_\_ Language Spoken \_\_\_\_\_  
Height: \_\_\_\_\_ ft. \_\_\_\_\_ in

**Residence Type:**  House/Duplex  Mobile Home/Trailer  Apartment/Condo  
**Living Situation:**  Living Alone  With Parents  With Family  With Non-Relative

Pets (If Yes, see back of form)

Name of Contact in your home: \_\_\_\_\_

### EMERGENCY CONTACTS

(Local) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

(Non-local) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### SPECIAL MEDICAL NEEDS

Check all that apply:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Medical dependence on electricity<br><input type="checkbox"/> Feeding pump<br><input type="checkbox"/> Medication requiring refrigeration<br><input type="checkbox"/> Suction equipment<br><input type="checkbox"/> Other _____ | <input type="checkbox"/> Mental health problem<br><input type="checkbox"/> Psychiatric, or personality disorder<br><input type="checkbox"/> Alzheimer's/Dementia<br><input type="checkbox"/> Obsessive compulsive disorder<br><input type="checkbox"/> Autism<br><input type="checkbox"/> Conduct disorder<br><input type="checkbox"/> Anxiety<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Other _____ | <input type="checkbox"/> Vision loss/impaired<br><input type="checkbox"/> Assistive device _____<br><input type="checkbox"/> Hearing loss/impaired<br><input type="checkbox"/> Assistive device _____<br><input type="checkbox"/> Mobility impairment<br><input type="checkbox"/> Assistive device _____<br><input type="checkbox"/> Service animal<br><input type="checkbox"/> Open wounds/Decubitus<br><input type="checkbox"/> Bedridden<br><input type="checkbox"/> Incontinence<br><input type="checkbox"/> Morbid obesity<br><input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Medical dependence on oxygen<br><input type="checkbox"/> O2 Concentrator, nebulizer, etc<br><input type="checkbox"/> Respirator dependent   | <input type="checkbox"/> Speech impaired<br><input type="checkbox"/> Assistive device _____   |   |
| <input type="checkbox"/> Assistance with administration of medications, including Insulin  |   |   |
| <input type="checkbox"/> Other _____   |   |   |
| <input type="checkbox"/> Cognitive impairment  |   |   |

### ASSISTANCE REQUIRED

Do you have a caregiver who will be with you? NO YES (Circle One)

If "Yes," Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you need transportation to a Special Needs shelter in the event of a disaster? NO YES (Circle One)

If "YES," Check One:  Bus  Car  Wheelchair  Van  Ambulance

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



## MEDICAL SUPPORT INFORMATION

Primary Doctor: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Home Health Agency: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Pharmacy: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Health Insurance Company: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Hospice: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Nurse Registry: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Home Medical Equipment Provider: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Dialysis Center: \_\_\_\_\_ Telephone: \_\_\_\_\_

## OTHER MEDICAL CONDITIONS

Allergies: \_\_\_\_\_  
\_\_\_\_\_  
Medications: \_\_\_\_\_  
\_\_\_\_\_  
Other medical problems: \_\_\_\_\_  
\_\_\_\_\_

## CONSENT

In case of emergency, I authorize rescuers to enter my home (Initial) \_\_\_\_\_.  
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: \_\_\_\_\_  
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.
- If you feel you need to go to a hospital during a disaster, you and your care provider must make those arrangements.
- 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
- If you will be bringing your pet to one of our pet friendly shelters, your animal will also need to register for sheltering. Animal Care and Control will be sending you a registration form and information on your pet care during an emergency.

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 TO:

Fire and Rescue Department  
Emergency Preparedness Division  
515 Julia Street, 4th Floor  
Jacksonville, Florida 32202  
Phone: 904-630-2472  
**FAX:** 904-630-0600

