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):

Name: ______________________________________

Sex: ☐ Male ☐ Female

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 ☐ Speech Impaired
☐ Mental Health Problem ☐ Alzheimer’s ☐ Vision Loss/Impaired
☐ Dementia ☐ Psychiatric or Personality Disorder: _______________________
☐ Developmentally Disabled ☐ Mobility Impaired
☐ Psychiatric or Personality Disorder: _______________________
☐ Speech Impaired ☐ Vision Loss/Impaired
☐ Hearing Loss/Impaired ☐ Service Animal
☐ Incontinence ☐ 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: _______________________

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

* Contact phone number required.
### Other Medical Information:

**Other Medical Concerns:**

________________________________________________________

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**Primary Doctor:** ______________________________________ Telephone: __________________

**Home Health Agency:** _________________________________ Telephone: __________________

**Pharmacy:** ____________________________________________ Telephone: __________________

**Dialysis Center Name:** _________________________________ Telephone: __________________

**Health Insurance Provider:** _____________________________ Telephone: __________________

**Home Medical Equipment Provider:** _____________________ Telephone: __________________

**Allergies:** ____________________________________________

**Medications:** _________________________________________

________________________________________________________

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### 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.

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**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).**