



City of Jacksonville / Duval County Special Medical Needs Registration Form



Personal Enrollment Data

Today's Date: _____

Full Name: _____ Gender: ☐ M ☐ F

Address: _____ Zip Code: _____ DOB: ____/____/____

Phone: _____ Alternate: _____ Email: _____ Age: _____

Weight: _____ lbs. Primary Language: _____ Pets: ☐ Yes ☐ No

Residence Type: ☐ House/Duplex ☐ Mobile Home/Trailer ☐ Apartment/Condo

Living Situation: ☐ Living Alone ☐ With Parents ☐ With Family/Friend

Emergency Contacts:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Special Medical Needs Assessment (Check all that apply):

Mobility <input type="checkbox"/> I can walk <input type="checkbox"/> Walker/cane <input type="checkbox"/> Wheelchair/scooter <input type="checkbox"/> Bedridden <input type="checkbox"/> Hoyer lift <input type="checkbox"/> Stretcher	Oxygen Dependent <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Health/ Behavioral <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Dementia/Alzheimers <input type="checkbox"/> Psychiatric/Personality Disorder	Dialysis Dependent <input type="checkbox"/> Yes <input type="checkbox"/> No Dialysis Center Name: Other Medical Concerns:
Electric Dependency <input type="checkbox"/> O2 concentrator <input type="checkbox"/> CPAP-BiPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Feeding Pump <input type="checkbox"/> Nebulizer <input type="checkbox"/> Suction <input type="checkbox"/> Refrigerated Medication <input type="checkbox"/> Other:	Cognitive/Physical <input type="checkbox"/> Autism/Developmental Delay <input type="checkbox"/> Speech Impaired <input type="checkbox"/> Vision Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Assistance administering medication <input type="checkbox"/> Incontinence <input type="checkbox"/> Open/Healing Wound <input type="checkbox"/> Morbid Obesity (>300 lbs) <input type="checkbox"/> Frail	

Do you have a caregiver who will be with you? ☐ Yes ☐ No (Required for memory impaired clients).

By signing this form, I give my authorization for the medical information contained herein to be released to the county health department, emergency management, local fire districts, and receiving facilities for the purpose of evaluating my needs and providing emergency transportation and sheltering. Records related to registration of disabled citizens are exempt for the provisions of F.S. 118.07(1), Public Records Law. The information contained here will be kept confidential.

Signature of Parent/ Guardian

Date Signed

MAIL to:

Jacksonville Fire & Rescue Department, Emergency Preparedness
Division 515 N. Julia Street, 4th Floor, Jacksonville, Florida 32202
Phone: 904-255-3172

Submit Electronically