

City of Jacksonville / Duval County Special Medical Needs Registration Form



Personal Enrollment Data			10	day's Da			
Full Name:				_	Gende	r: □ M	□ F
Address:			Zip Code:	DOB_	/	/_	/
Phone:	Alternate:	Email_		,	Age:	-	
Weight:lbs	s. Primary Langua	ge:		_ Pets:	□ Yes □	No_	
Residence Type: 🗆 Ho	ouse/Duplex 🗆 Mobi	le Home/Trailer	□ Apartment/Condo				
Living Situation: □ Li	ving Alone □ With	Parents 🗆 V	Vith Family/Friend				
Emergency Contacts:							
Name:	Re	elationship:	Phone:				
Name:	Re	elationship:	Phone: _				
Special Medical Needs Ass	<u>essment</u> (Check <u>all</u> that	apply):					
Mobility	Oxygen Depen	dent	Dialysis Depende	nt			
□ I can walk	□ Yes □ N	0	□ Yes	□ No			
□ Walker/cane			Dialysis Center N	ame:			
☐ Wheelchair/scoote	er Mental Health	/ Behavioral					
□ Bedridden	□ Anxiety/De	pression					
☐ Hoyer lift	□ Dementia/A	Alzheimers	Other Medical	Concerns	:		
□ Stretcher	☐ Psychiatric/	Personality Disor	der				
Electric Dependency	,	,					
□ O2 concentrator	Cognitive/Phys	sical					
□ CPAP-BiPAP	□ Autism/Dev	elopmental Delay	I				
□ Ventilator	□ Speech Imp	•	•				
☐ Feeding Pump	□ Vision Impa						
□ Nebulizer	□ Hearing Im						
□ Suction	- ·	administrating me	edication				
☐ Refrigerated Medi		J					
	□ Open/Heali						
□ Other:	= - ,	•					
□ Other:	□ Morbid Obe	こうじん ハーンハハ いりつ					