



## Florida Special Needs Registry

### Registration Information - Neptune Beach

Form

**35**Rev.  
09/22

Instructions: Complete this form and fax or mail it to the Neptune Beach Police Department to register an individual for the Florida Special Needs Registry. Required fields are indicated with an asterisk (\*).

Mail: Neptune Beach Police Department  
ATTN: Special Needs Registry  
200 Lemon Street  
Neptune Beach, FL 32266

Fax: (904) 270-2426

Email: info@nbfl.us

#### PERSONAL INFORMATION ABOUT THE REGISTRANT

*First Name		*Last Name	
*Birth Date		*Primary Language	
*Registrant Phone Number		*Phone Type	<input type="checkbox"/> Home <input type="checkbox"/> Cell
*Email			
*Gender (select only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Non-Binary <input type="checkbox"/> Prefer Not To Provide		
Height	Feet: <input type="checkbox"/> Unable to Verify	Inches: <input type="checkbox"/> Unable to Verify	Weight lbs <input type="checkbox"/> Unable to Verify
		*Pet: <input type="checkbox"/> Yes <input type="checkbox"/> No	Service Animal <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you completing this form on behalf of the registrant? If so, please indicate your relationship to the registrant (select only one)		<input type="checkbox"/> Family Member <input type="checkbox"/> Caregiver <input type="checkbox"/> Neighbor <input type="checkbox"/> Friend <input type="checkbox"/> Health Care Provider <input type="checkbox"/> County Emergency Management Staff <input type="checkbox"/> County Health Department Staff <input type="checkbox"/> DOH State Staff	

#### REGISTRANT'S EQUIPMENT

Electrical Dependency Needs: (select all that apply)	<input type="checkbox"/> Apnea Monitor	<input type="checkbox"/> Feeding Pump	<input type="checkbox"/> Suction Pump
	<input type="checkbox"/> Trilogy <input type="checkbox"/> Ventilator	<input type="checkbox"/> CPAP / BiPAP	<input type="checkbox"/> Dialysis Catheter
	<input type="checkbox"/> Nebulizer	<input type="checkbox"/> Wound Vac	<input type="checkbox"/> Cardiac Monitor
	<input type="checkbox"/> Oxygen Concentrator	<input type="checkbox"/> Medication that requires refrigeration	
	<input type="checkbox"/> Other:		

#### EMERGENCY CONTACT FOR THE REGISTRANT (required)

*Primary Emergency Contact Name		*Relationship	
*Contact Primary Phone Number	Ext:	Phone Type	<input type="checkbox"/> Home <input type="checkbox"/> Cell
*Secondary Emergency Contact Name		*Relationship	
*Contact Primary Phone Number	Ext:	Phone Type	<input type="checkbox"/> Home <input type="checkbox"/> Cell

#### ADDRESS FOR THE REGISTRANT (physical address is required)

*Physical Address (cannot be a PO Box)			
Apt #, Unit #, Bldg #, Suite #, etc.			
*Physical City	*Physical State	FL	*Physical Zip Code



## Florida Special Needs Registry (cont.)

### Registration Information - Neptune Beach

Form

**35**Rev.  
09/22

#### TRANSPORTATION & MOBILITY

<b>Registrant has the following transportation needs:</b> (select all that apply)	<input type="checkbox"/> Jacksonville Transportation Authority <input type="checkbox"/> Wheelchair Accessible Vehicle <input type="checkbox"/> Ambulance
<b>Registrant has the following mobility issues:</b> (select all that apply)	<input type="checkbox"/> Is confined to a bed <input type="checkbox"/> Is paralyzed (complete or partial) <input type="checkbox"/> Uses a Hoyer Lift <input type="checkbox"/> Uses a Cane <input type="checkbox"/> Uses a Walker <input type="checkbox"/> Uses a Motorized Wheelchair/ Scooter

#### MEDICAL & OTHER

<b>Memory: (select all that apply)</b> (Caregiver required for memory impaired clients)	<input type="checkbox"/> Alzheimer and related dementia <input type="checkbox"/> Dementia <input type="checkbox"/> Memory Impaired		
<b>Mental or Behavioral:</b> (select all that apply)	<input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar <input type="checkbox"/> Flight risk <input type="checkbox"/> Psychosis <input type="checkbox"/> Personality Disorder <input type="checkbox"/> Obsessive/Compulsive <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Conduct Disorder <input type="checkbox"/> Combative/Violent <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Self-injurious or danger to others <input type="checkbox"/> Autism/Developmental Delay <input type="checkbox"/> Other		
<b>Dialysis Dependent:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Oxygen Dependent:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Other Medical Conditions:</b> (select all that apply)	<input type="checkbox"/> Vision Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Speech Impaired <input type="checkbox"/> Incontinent <input type="checkbox"/> Seizures <input type="checkbox"/> Foley Catheter <input type="checkbox"/> Diabetic <input type="checkbox"/> Open/Healing Wound <input type="checkbox"/> Pacemaker <input type="checkbox"/> Colostomy/Ileostomy <input type="checkbox"/> Other		