Florida Special Needs Registry
Registration Information - Osceola County

Instructions: Complete this form and fax or mail it to Osceola County to register an individual for the Florida Special Needs Registry. This form is not required if you have already registered on line. Required fields are indicated with an asterisk (*).

Mail: Osceola County Special Needs Registry
2586 Partin Settlement Road
Kissimmee, FL 34744

Fax: (407) 742-9022

PERSONAL INFORMATION ABOUT THE REGISTRANT	
*First Name	
Middle Name	
*Last Name	
Suffix	
*Birth Date	
*Gender (select only one)	☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Prefer Not To Provide
*Height	Feet: Inches:
*Weight (pounds)	
Living Situation (select only one)	☐ Live alone ☐ Live with relative or caregiver ☐ Other living situation
*Primary Language	
Secondary Language	
Veteran	☐ Yes ☐ No
Last 4 digits of SSN	
Email Address	
Are you completing this form on behalf of the registrant? If so, please indicate your relationship to the registrant (select only one)	☐ Family Member ☐ Caregiver ☐ Neighbor ☐ Friend ☐ Health Care Provider ☐ County Emergency Management Staff ☐ County Health Department Staff ☐ DOH State Staff

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	
Name of Complex, Subdivision or Mobile Home Park	
Is the home at this address a mobile home?	☐ Yes ☐ No
Is the home at this address a highrise or multi-story home?	☐ Yes ☐ No
Does this home have stairs?	☐ Yes ☐ No
Is there a code required to enter?	
Do you live at this address year round?	☐ Yes ☐ No If No, from month:_____ To month:_____

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ADDRESS FOR THE REGISTRANT (physical address is required)	
Mailing Address (if different from above)	
Mailing City	
Mailing State	
Mailing Zip Code	

PHONE NUMBERS FOR THE REGISTRANT (a primary and at least one other phone number is required)				
*Phone Number	Extension	*Phone Type (select only one)	Primary	TTY/TDD Capable
		☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No	☐ Yes ☐ No

PRIMARY EMERGENCY CONTACT FOR THE REGISTRANT (required)	
*Primary Emergency Contact Name	
Contact Address	
Contact City	
Contact State	
Contact Zip Code	
*Contact Primary Phone Number	Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Secondary Phone Number	Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Email Address	

OTHER CONTACTS FOR THE REGISTRANT (entry is optional)	
*Other Contact Name	
*Contact Type (select only one)	☐ Secondary Emergency Contact ☐ Caregiver ☐ Family Member ☐ Neighbor ☐ Friend ☐ Physician ☐ Pharmacy ☐ Home Health Care Provider ☐ Home Medical Equipment Provider ☐ Hospice Provider ☐ Oxygen Provider ☐ Dialysis Clinic ☐ Other Medical Provider ☐ Out Of Area Contact ☐ Alternate Living Arrangement Contact
Contact Address	
Contact City	
Contact State	
Contact Zip Code	
*Contact Primary Phone Number	Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Secondary Phone Number	Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No

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OTHER CONTACTS FOR THE REGISTRANT (entry is optional)	
Contact Email Address	
*Other Contact Name	
*Contact Type (select only one)	☐ Secondary Emergency Contact ☐ Caregiver ☐ Family Member ☐ Neighbor ☐ Friend ☐ Physician ☐ Pharmacy ☐ Home Health Care Provider ☐ Home Medical Equipment Provider ☐ Hospice Provider ☐ Oxygen Provider ☐ Dialysis Clinic ☐ Other Medical Provider ☐ Out Of Area Contact ☐ Alternate Living Arrangement Contact
Contact Address	
Contact City	
Contact State	
Contact Zip Code	
*Contact Primary Phone Number	Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Secondary Phone Number	Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Email Address	
Additional County Information	
*Will the companion/caretaker listed above accompany you to shelter?	☐ Yes ☐ No

REGISTRANT'S PETS

*Pet Name	*Type of Animal	*Breed / Description	Vaccinations Up to Date	Will Bring to Shelter	Requires Medication	Other information about this pet
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

REGISTRANT'S SERVICE ANIMALS

*Animal Type (select only one)	*Required Due to Disability	*Work or Task Animal has been trained to perform
☐ Dog ☐ Miniature Horse	☐ Yes ☐ No	
☐ Dog ☐ Miniature Horse	☐ Yes ☐ No	
☐ Dog ☐ Miniature Horse	☐ Yes ☐ No	

REGISTRANT'S EQUIPMENT

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REGISTRANT'S EQUIPMENT

Please indicate the medically necessary equipment that is electric dependent for this registrant: (select all that apply)	☐ Apnea Monitor ☐ Cardiac Monitor ☐ CPAP / BiPAP ☐ Dialysis Catheter ☐ Electric Insulin pump ☐ Feeding Pump ☐ Medication that requires refrigeration ☐ Nebulizer ☐ Oxygen Concentrator ☐ Suction Pump ☐ Ventilator ☐ Wound Vac Other:
Please indicate any medically necessary equipment that is NOT electric dependent for this registrant: (select all that apply)	☐ EpiPen ☐ Indwelling Urinary Catheter (Foley) ☐ Insulin Pump ☐ Peripheral Intravenous Line ☐ PICC Line ☐ Port-a-Cath ☐ Pulse Oximeter ☐ Tracheostomy

TRANSPORTATION & MOBILITY

Registrant has the following transportation needs: (select all that apply)	☐ Needs transportation to a shelter ☐ Can be transported in a car ☐ Can be transported in a bus ☐ Must be transported in a wheelchair accessible vehicle ☐ Must be transported in a stretcher van ☐ Uses a wheelchair but can transfer to a van seat ☐ Weight requires special transportation ☐ Needs continuous oxygen during transport Caregiver(s) needs transportation: Other shelteree(s) needs transportation:
Registrant has the following mobility issues: (select all that apply)	☐ Needs help to walk ☐ Needs help transferring to/from cot and/or mobility device ☐ Uses a Hoyer Lift to get out of a cot ☐ Is confined to a bed ☐ Paraplegic ☐ Quadriplegic ☐ Uses a Walker ☐ Uses a Cane ☐ Uses a Wheelchair ☐ Uses a Motorized Wheelchair / Scooter Other:

Additional County Information

*Do you require transportation to a shelter? (select only one)	◯ Yes ◯ No ◯ Maybe

MEDICAL & OTHER

Behavioral: (select all that apply)	☐ Anxiety ☐ Autism ☐ Bipolar ☐ Combative / Violent ☐ Conduct Disorder ☐ Flight Risk ☐ Obsessive / Compulsive ☐ Personality Disorder ☐ Psychosis ☐ Schizophrenia ☐ Self-injurious or danger to others ☐ Substance Abuse Other:
Memory: (select all that apply)	☐ Alzheimer's and related dementias ☐ Dementia ☐ Memory Impaired
Dialysis: (select all that apply)	☐ Hemodialysis (Facility/Home) ☐ Peritoneal Dialysis
Name of Primary Insurance Company:	
Dialysis Frequency: (select only one)	◯ 1 time a week ◯ 2 times a week ◯ 3 times a week ◯ 4 times a week ◯ 5 times a week ◯ 6 times a week ◯ 7 times a week (daily)
Insurance ID #:	

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MEDICAL & OTHER				
Oxygen Type: (select only one)	☐ Gaseous	☐ Liquid		
Do you have a Do Not Resuscitate (DNR) order? IMPORTANT: If yes, please remember to bring the original yellow copy with you to the Special Needs Shelter.	☐ Yes	☐ No		
Oxygen Liter Flow / Amount: (select only one)	☐ 0.5 ☐ 2.5 ☐ 4.5 ☐ 6.5	☐ 1.0 ☐ 3.0 ☐ 5.0 ☐ 7.0	☐ 1.5 ☐ 3.5 ☐ 5.5 ☐ > 7.0	☐ 2.0 ☐ 4.0 ☐ 6.0
Oxygen Mode of Administration: (select only one)	☐ Mask	☐ Nasal Cannula	☐ Trach Collar	
Medicaid #:				
Medicare #:				
Medication Allergies & Reactions (list all)				
Do you need assistance with administering your medications?	☐ Yes	☐ No		
Other: (select all that apply)	☐ Vision Impaired ☐ Deaf ☐ Asthma ☐ COPD ☐ Incontinent ☐ Difficulty speaking ☐ Hypotension (Low Blood Pressure) ☐ Colostomy ☐ Parkinsons	☐ Partially Blind ☐ ALS ☐ Cancer ☐ Cystic Fibrosis ☐ IV Pump ☐ Emphysema ☐ Kidney Disease ☐ Ileostomy ☐ Peritoneal Dialysis Pump	☐ Legally Blind ☐ Arthritis / Osteoporosis ☐ Cerebral Palsy ☐ Diabetes (Type 1) ☐ Non verbal ☐ Heart Disease ☐ MS ☐ Urostomy ☐ Stroke	☐ Hearing Impaired ☐ Angina ☐ Congestive Heart Failure ☐ Diabetes (Type 2) ☐ Difficulty understanding verbal instructions ☐ Hypertension (High Blood Pressure) ☐ Muscular Dystrophy ☐ Pacemaker / AICD
	Bedsore (Decubitus Ulcer):			
	Contagious Disease:			
	Food Allergies & Reactions:			
	Seizures:			
	Other:			

REGISTRANT'S MEDICATION (Use additional paper if more space needed)			
*Name of Medication	Dosage	Route	Requires Refrigeration
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal ☐ Inhaled	☐ Yes ☐ No

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REGISTRANT'S MEDICATION (Use additional paper if more space needed)					
*Name of Medication	Dosage	Route			Requires Refrigeration
		☐ Auto Injector ☐ IV ☐ Subcutaneous ☐ Transdermal	☐ Injection ☐ Mouth ☐ Sublingual ☐ Inhaled		○ Yes ○ No
		☐ Auto Injector ☐ IV ☐ Subcutaneous ☐ Transdermal	☐ Injection ☐ Mouth ☐ Sublingual ☐ Inhaled		○ Yes ○ No
		☐ Auto Injector ☐ IV ☐ Subcutaneous ☐ Transdermal	☐ Injection ☐ Mouth ☐ Sublingual ☐ Inhaled		○ Yes ○ No
		☐ Auto Injector ☐ IV ☐ Subcutaneous ☐ Transdermal	☐ Injection ☐ Mouth ☐ Sublingual ☐ Inhaled		○ Yes ○ No
		☐ Auto Injector ☐ IV ☐ Subcutaneous ☐ Transdermal	☐ Injection ☐ Mouth ☐ Sublingual ☐ Inhaled		○ Yes ○ No
		☐ Auto Injector ☐ IV ☐ Subcutaneous ☐ Transdermal	☐ Injection ☐ Mouth ☐ Sublingual ☐ Inhaled		○ Yes ○ No

OTHER NOTES ABOUT THE REGISTRANT