Special Needs Alert Program

IDENTIFYING INFORMATION:

Name: Last Name First Name Middle

Nicknames or Alias: _____

Sex: Male Female **Race**: White Black Asian/Pacific Islander **Ethnicity**: Hispanic Non-Hispanic

Date of Birth: _____ Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Identifying Markers (Scars, Marks, Tattoos, Glasses, Piercings, etc.): _____

Home Address: _____

Address City State Zip

School Name and Address (if applicable): _____

_____

Address City State Zip

Cell Phone (if applicable): _____ Cell Phone Provider: _____

Vehicle Information (if applicable): _____

_____

License Plate # State Year Make Model Color

MEDICAL INFORMATION:

Type of Disability: _____

Check if applicable: Visually Impaired Hearing-Impaired Speech Impaired

Known Allergies (Food, Medications, etc.): _____

Doctor Name: _____ Phone: _____

Any Other Pertinent Medical Issues / Information: _____

_____

ADDITIONAL INFORMATION:

Where are they known to go? (If known to wander or leave the residence):_____

Triggers (Example: Reaction to touch / loud noises / Bright light): _____

Visual or Verbal Prompts (Example: Keywords they react to / Picture of a house):_____

EMERGENCY CONTACT INFORMATION:

1. Name: _____ Relationship: _____

Address: _____

Address City State Zip

Cell Phone: _____ Home Phone: _____ Work: _____

2. Name: _____ Relationship: _____

Address: _____

Address City State Zip

Cell Phone: _____ Home Phone: _____ Work: _____

I hereby attest that I am freely and voluntarily providing the information contained in this form and a photograph (Digital Preferred) to the Elm Ridge Police Department with the express intent that the Department maintain the information in its files and may use the information for any lawful purpose. I understand that certain information in this form may be considered protected medical and/or identifiable health care information. I further understand that the Department is not a health care provider and/or covered entity under HIPPA for the purposes of the collection and use of any protected medical and/or identifiable health information. I attest that I am freely and voluntarily providing the information to the Department for record keeping and lawful use. I further attest that I am authorized to provide all the foregoing information to the Department.

_____

Printed Name Signature Relationship Date

OFFICIAL USE: □ RMS □ CAD

Notes: _____

Rev. Date: 6/13/2022