City of Pacifica Special Needs Registry **Age:**

Confidential Information about Person with Special Needs Date: ☐ ☐

Last Name | First Name | Initial | Nickname (if any)

Date of Birth: ☐ Male ☐ Female

Hair Color: Eye Color:

Height: Weight:

Race:

Diagnosis/Disability:

Identifying Features (scars, moles, etc.)

Identification on Person (ID bracelet, necklace, tags, EMFINDERS locator device, other device):

Attach
Recent Photo Here

(Identification-type photo
or school photo
clearly showing the person's
facial features)

Suggestions for approaching person and de-escalation techniques: **Photo Date:**

Home Address

Address: Apt. Does the individual live alone? ☐ Yes ☐ No

City: St: ZIP: Is this a ☐ Family home ☐ Group home

Home Phone: Cell Phone:

Emergency Contact Information

Contact Person(s): ☐ Parent(s) ☐ Guardian/Caregiver

Address: Apt. Other Relationship

City: St: ZIP:

Home Phone: Cell Phone:

Email Address (for administrative use, not emergency use):

Check Here ☐ to receive an email reminder when it is time to update this form.

Behavioral Information

Does this person tend to wander off or elope? ☐ Yes ☐ No ☐ Sometimes

Favorite Attractions/Locations where person may be found:

Describe any behaviors or characteristics that may attract attention or endanger this person:

Other important information or suggested accommodations:

Alternate Emergency Contact Information

Contact Person(s): ☐ Parent(s) ☐ Guardian/Caregiver

Address: Apt. Other Relationship

City: St: ZIP:

Phone: Cell Phone:

Communication Information

Primary Language: Second Language:

Communication Method if non-verbal/low-verbal (picture cards, sign language, written words, communication device):

Medical Information

Please indicate the nature of the special need(s) and any medical condition(s) that may apply:

☐ Alzheimer's Disease ☐ Autism ☐ Asperger Syndrome ☐ Bipolar Disorder ☐ Cerebral Palsy
☐ Developmental Disability ☐ Diabetes ☐ Down Syndrome ☐ Emotional Disturbance ☐ Epilepsy/seizures
☐ Hearing Impairment ☐ Oppositional Defiant Disorder ☐ Schizophrenia ☐ Visual Impairment

Other Condition(s)

Physician Contact: Phone:

Physician Contact: Phone:

Medication(s) and Dosage:

Medical, Dietary, Sensory Issues and Requirements:

Medical Devices or Equipment Used:

I understand that completion of this form is voluntary and does not confer any rights to actions, activities or measures undertaken by the Pacifica Police Department. I further understand that the provision of any and all health related information in this form is voluntary and that I am willingly providing said information in light of any and all related and applicable privacy laws.

Name of person completing this form | Signature of Person completing form | Date

Deliver this completed form with photograph attached to:

The Pacifica Police Department, attention Special Needs Registry, 2075 Coast Highway, Pacifica, CA 94044

or send it via email to **specialneedsregistry@pacificapolice.org**.