The Cheshire Police Department
500 Highland Ave
Cheshire, CT 06410
(203) 271-5500
INDIVIDUALS WITH SPECIAL NEEDS QUESTIONNAIRE

Please take the time to fill out the following three pages completely and as accurately as possible and return it to the Cheshire Police Department. Our goal is to supply responding Police, Fire, and Ambulance personnel with current/accurate information in order to deal with your emergency in a caring and professional manner.

NOTE: ***Please complete form and return it to the Cheshire Police Department at the address above. Please include a recent photograph if possible.***
Photo ID's can also be produced after the return of the registry by appointment: Please contact Ofc. Gretchen Ovesny (203)271-5576 or govesny@cheshirect.org

Circle One: **New Registry** **Update to existing Registry**

DESCRIPTION OF SPECIAL NEEDS:

Medical Condition or description of special need:

_____

_____

_____

Name of child/adult:_____

D.O.B._____**Sex**_____**Race**_____

Address:_____**Height:**_____**Weight:**_____
Hair Color:_____**Eye Color:**_____**Nicknames:**_____
Glasses or Hearing Aide _____
Scars, Marks, Tattoos, Piercings: _____

_____

ID Wear: □ jewelry □ tags on clothes □ printed handout card □ tracking monitor □Other_____
Parent or Guardian Name: _____
Home # ( )_____**Cell #( )**_____**Work #( )**_____
Pager # ( )_____**email address:** _____
Parent or Guardian Name: _____
Home # ( )_____**Cell #( )**_____**Work #( )**_____
Pager # ( )_____**email address:** _____

ADDITIONAL CAREGIVER:

Name:_____
Address:_____
Home #:( )_____ **Cell #:**( )_____ **Work #:**( )_____
Pager # ( )_____ **email address:** _____

EMERGENCY CONTACT:

Name:_____
Address:_____
Home #:( )_____ **Cell #:**( )_____ **Work #:**( )_____
Pager # ( )_____ **email address:** _____

METHOD of COMMUNICATION:

⎦ **Child communicates verbally**
If non-verbal, the best way to communicate with the child is:
⎦ **sign language □ picture boards □ written word**
⎦ **other**_____

MEDICAL CARE PROVIDERS:

Physicians Name:_____ **Phone #**( )_____
Address:_____
Physicians Name:_____ **Phone #**( )_____
Address:_____
Dentist Name:_____ **Phone #**( )_____
Address:_____

CURRENT PRESCRIPTIONS (including dosage):

_____
_____
_____
_____

SENSORY, MEDICAL, or DIETARY ISSUES and RECOMMENDATIONS:

_____
_____
_____
_____

INCLINATION FOR WANDERING AND ANY "A" TYPICAL BEHAVIORS or CHARACTERISTICS THAT MAY ATTRACT ATTENTION:

_____
_____
_____
_____

FAVORITE ATTRACTIONS, LOCATIONS WHERE PERSON MAY BE FOUND:

_____
_____
_____
_____

LIKES, DISLIKES, APPROACH and DE-ESCALATION TECHNIQUES:

_____
_____
_____
_____

ANY OTHER PERTINENT INFORMATION:

_____
_____
_____
_____
_____
_____
_____

The under signed parent / guardian authorizes the information contained in this questionnaire to be entered into a computer database that may be utilized by emergency personnel.

_____ _____ _____
Print Name Signature Date

Below for police use only

Received By CPD: Date: / / By:_____
Entered Into System: Date: / / By:_____
Logged into Shift Cmdrs Binder: Date: / / By:_____