

**Confidential Information about Person with Special Needs**

Date: \_\_\_\_\_ NEW UPDATE

\_\_\_\_\_  
Last Name First Name

\_\_\_\_\_  
Initial Nickname (if any)

Date of Birth: \_\_\_\_\_ Male Female

Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

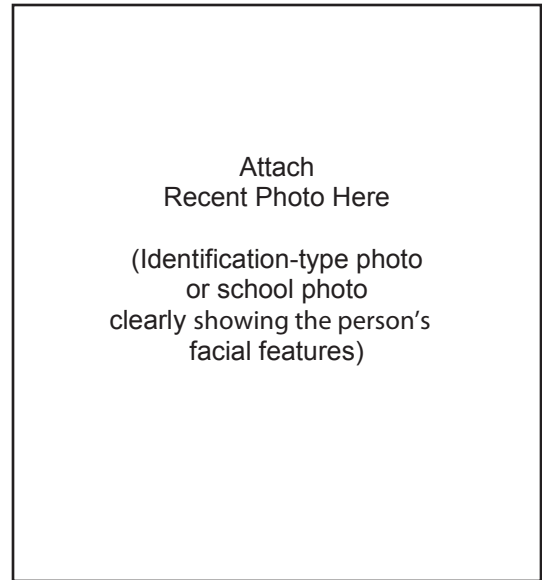
Height: \_\_\_\_\_ Weight \_\_\_\_\_

Race: \_\_\_\_\_

**Diagnosis/Disability:** \_\_\_\_\_

Identifying Features (scars, moles, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

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



**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:

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Other important information or suggested accommodations:

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**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:

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Medical Devices or Equipment Used: \_\_\_\_\_

*I authorize the release of this information to Sheriff Department personnel for official use to help identify and assist me, my family member, ward or client during an emergency. The form may also be used by program representatives for administrative purposes. I understand that completion of this form is voluntary and does not guarantee any special treatment. I acknowledge that I am responsible for the accuracy of the information and for updating the information when it changes and that the information will be removed from the system and destroyed if not updated after two years.*

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

Mail this completed form with photograph attached to:  
Family Focus Resource Center, Attention Andja Bozic 25360 Magic Mountain Parkway, Suite 150 Santa Clarita, CA 91355  
The Special Needs Registry is a public/private partnership between the City of Santa Clarita, the Los Angeles County Sheriff's Department and community collaborators. For more information visit [www.clearscv.org](http://www.clearscv.org)