Santa Clarita Valley Special Needs Registry Age:_____

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):

_____

_____

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 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.

_____ _____ _____

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