

S.A.ID.

SPECIAL NEEDS ALERT &
IDENTIFICATION PROGRAM



PARTICIPATION FORM

If you are a parent, guardian, or caregiver of an individual with medically diagnosed special needs, please complete the following form to participate in the program. Answer all questions completely and accurately as this information will be utilized to create the alert in our database. If you have a question regarding any portion of the form, send an email to said@sand springsok.org

Information on the Individual in need of S.A.Id Alert:

Name of participant

First: _____ Middle: _____ Last: _____

Date of Birth: _____ Nickname: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Race: _____

Gender: _____ Height: _____ Weight: _____

Hair Color: _____ Eye Color: _____

Please List Any Physical Identifiers (Scars/Marks/Tattoos/Physical Conditions):

What are the individual's special needs? (Check All That Apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Visually-Impaired | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Cognitively / Developmentally Delayed |
| <input type="checkbox"/> Legally Blind | <input type="checkbox"/> Speech Impaired | <input type="checkbox"/> Mood Disorder / Mental Illness |
| <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Paralysis (Full or Partial) |
| <input type="checkbox"/> Deaf | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Immobile | <input type="checkbox"/> Downs Syndrome | <input type="checkbox"/> Alzheimer's / Dementia |
| <input type="checkbox"/> Non-Verbal | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Autism Spectrum Disorder/Asperger Syndrome |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Other: _____ |

Which of the following apply to this individual? (Check All That Apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Responds to verbal commands | <input type="checkbox"/> Responds well to touch | <input type="checkbox"/> High pain tolerance |
| <input type="checkbox"/> Communications / speech delay | <input type="checkbox"/> Light/ Siren Sensitivity | <input type="checkbox"/> Wheelchair/ walker/ cane |
| <input type="checkbox"/> Communicates with PECS | <input type="checkbox"/> Sound Sensitivity | <input type="checkbox"/> Tendency to Wander |
| <input type="checkbox"/> Communicates with Sign Language | <input type="checkbox"/> Uses Hearing aids | <input type="checkbox"/> Fascination with water |
| <input type="checkbox"/> Scared of fast movement/crowd's | <input type="checkbox"/> Color Sensitivity | <input type="checkbox"/> Tendency to hide |
| <input type="checkbox"/> Use of eyeglasses | <input type="checkbox"/> Other: _____ | |

Are they known to wander? Yes No

What upsets this individual? _____

What behavior is exhibited when upset? _____

What is their safety item or something that calms them down? _____

What is their favorite place or a common hiding place inside the home? _____

What is their favorite place or a common hiding place outside of the home? _____

Name of School or Daycare: _____

Address Street: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Primary Emergency Contact:

Name of contact

First: _____ Middle: _____ Last: _____

Relationship: _____ Date of Birth: _____

Home Address Street: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Secondary Emergency Contact:

Name of contact

First: _____ Middle: _____ Last: _____

Relationship: _____ Date of Birth: _____

Home Address Street: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Photo:

Please attach a recent head and shoulders photo of the individual. If possible, please also send a digital version of the photo (png or jpeg format) to **said@sandsspringsok.org**. Make sure to include the individual's name and date of birth in the email.

AUTHORIZATION FOR ALERT:

By submitting this form, I certify that the information provided is true and accurate to the best of my knowledge. I understand that I voluntarily provided this information listed in this form and that it will not result in any type of preferential treatment from First Responders. I hereby grant the Sand Springs Police Department to create an alert utilizing the above information and consent to that information being shared with the Sand Springs Fire Department and any other responding First Responders.

_____ I Agree (Initial)

Signature _____ Date _____