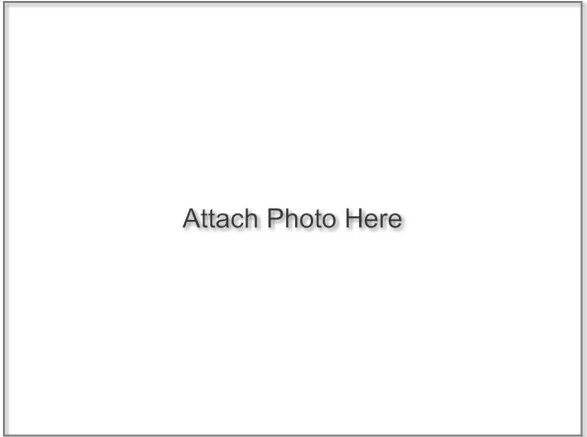




Carlyle Police Department Special Needs Registry



Date: _____

Name: _____ Nicknames: _____

Address: _____

Phone: _____ Cell Provider: _____

Sex: _____ Race: _____ Date of Birth: _____ Height: _____ Weight: _____ Eyes: _____ Hair: _____

Scars/Marks/Tattoos/Identification Worn: _____

Disability/Illness: _____

Please list any specific medical concerns: *(Allergies, preferred hospital, etc.)* _____

Can the person Drive? Yes/No Vehicle Information: _____

Locations person may frequent: _____

Best Methods of Communication: _____

Best Methods of Approach: _____

Behaviors exhibited when upset/frustrated: _____

Best Ways to Calm: _____

Other helpful advice or comments not already covered: _____

Emergency Contact Information:

1.

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

2.

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

3.

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

I understand that participation in this program is voluntary and it is my responsibility to keep the information provided updated.

Signature and Date