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, EMFINDERS 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