Santa Clarita Valley Special Needs Registry				Age:					
Confidential Information	on about Person	with Special Nee	eds Date:		NEW	UPDATE			
Last Name	First Nar	ne	Initial	Nickname (if an	y)				
Date of Birth:		Male Female	·						
Hair Color:	Eye Color:								
Height:	Weight								
Race:				Attac Recent Pho					
Diagnosis/Disability:				(Identification-					
Identifying Features (scars	, moles, etc.)			or school clearly showing facial fea	photo the person	's			
Identification on Person (II locator device, other device			6						
Suggestions for approach				Photo Date:					
Address:		•		the individual live		res No			
City:				•	/ home (Group home			
Home Phone:		_ Cell Phone:							
Emergency Contact Info			Donous	t(a) Overdien	(Conocina)				
Contact Person(s):				,					
Address:		•		Relationship					
Home Phone:									
Email Address (for adminis									
Check Here to re	eceive an email rem	inder when it is time	e to update thi	s torm.					
Behavioral Information Does this person tend to w	vander off or elone?	Yes No	Sometimes						
·	·								
Favorite Attractions/Locati	ons where person m	iay be lound:							

Describe any behaviors or characteristics that may attract attention or endanger this person:

Santa Clarita Valley Special Needs Registry

Other important information or s	uggested accom	modations:					
Alternate Emergency Contact	Information						
Contact Person(s):			Parent(s)	Guardian/Caregiver			
Address:		Apt	Other Relation	ship			
City:	St:	_ ZIP:					
Phone:	Cell P	hone:		_			
Communication Information							
Primary Language:	Second Language:						
Communication Method if non-v	erbal/low-verbal	(picture cards, sign lang	guage, written w	ords, comn	nunication device):		
Medical Information Please indicate the nature of the □ Alzheimer's Disease □Developmental Disability □Hearing Impairment Other Condition(s)	□Autism □Diabetes □Oppositional [□Asperger Syndrome □Down Syndrome Defiant Disorder	□Bipolar Disor □Emotional Di □Schizophren	der sturbance ia	□Cerebral Palsy □Epilepsy/seizures □Visual Impairment		
		Phone: Phone:					
Physician Contact: Medication(s) and Dosage:							
Medical, Dietary, Sensory Issue	s and Requireme	ents:					
Medical Devices or Equipment (Jsed:						
I authorize the release of this in my family member, ward or clie administrative purposes. I unde treatment. I acknowledge that I it changes and that the informat	nt during an eme rstand that comp am responsible i	rgency. The form may a letion of this form is volu for the accuracy of the ii	also be used by untary and does nformation and t	program re not guarar for updating	epresentatives for ntee any special g the information when		
Name of person completing this form		Signature of Person comp	Da	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