POLICE DEPARTMENT COUNTY OF SUFFOLK, NY
ACCREDITED LAW ENFORCEMENT AGENCY

PDCS-8060d

SPECIAL NEEDS/SILVER ALERT PROGRAM

A Program for Persons with Special Needs

PERSON WITH SPECIAL NEEDS INFORMATION:

Last Name: ______________________ **First Name:** ______________________

Street Address: ______________________

City: ______________________ **State:** ________ **Zip:** ____________ **Phone:** ______________________

PERSONAL DESCRIPTION

DOB: ____________ **Race/Ethnicity:** ______________________ **Hair:** ______________ **Sex:** ❑ Male ❑ Female

Eyes: ______________ **Hgt:** ______________ **Wgt:** ______________ **Glasses:** ❑ Yes ❑ No

Scars/ Birthmarks/Tattoos: ______________________

❑ Dementia (e.g. Alzheimer's) ❑ Developmental Disabilities (e.g., Autism Spectrum, Mental Retardation/Intellectual Impairment)

❑ Severe Mental Illness ❑ Other cognitive disorders that may impair reasoning, resulting in a person wandering or becoming disoriented/lost

Medical Diagnosis: ______________________ **Allergies:** ______________________

Medications: ______________________

Able to walk: ❑ Yes ❑ No ❑ Verbal ❑ Non Verbal **Will respond to his /her name?** ❑ Yes ❑ No

If non verbal, can communicate in what form (e.g., signing, pictures, written) ______________________

Would you like a Silver Alert Bracelet mailed to you? ❑ Yes ❑ No **Bracelet #:**______________________ (Assigned by P.D.)

Did you enclose a recent photo of the person you wish to register with their name and DOB on the back of the photo? ❑ Yes ❑ No

EMERGENCY CONTACTS

Name: ______________________ **Relationship:** ______________________

Address: ______________________

E-mail: ______________________ **Phone:** (H) ______________________ (C) ______________________

Name: ______________________ **Relationship:** ______________________

Address: ______________________

E-mail: ______________________ **Phone:** (H) ______________________ (C) ______________________

Please provide additional information that will aid responding emergency personnel to assist in the safety and care of the above-named person.

How did you hear about our services? ______________________

RELEASE/DISCLAIMER

I, ______________________ give my permission as the Parent/Guardian of the above individual, to the Suffolk County Police Department to retain and distribute this information to first responding personnel (Fire, EMS, Police) and media for the sole purpose of identification and assistance to the above person with special needs. The completion of this form shall not create a right to services, nor shall it create a special relationship between the parties. The Suffolk County Police Department will make reasonable effort to relay provided information to responding personnel. The Department, however, shall not be held responsible for failure to do so and no guarantee is made, expressed, or implied that said information will be relayed.

IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO NOTIFY SCPD OF ANY CHANGE IN STATUS.
ALERTS ARE AUTOMATICALLY REMOVED FROM THE SYSTEM 24 MONTHS FROM THE ENTRY DATE.
THEREFORE, ALERTS MUST BE RENEWED BY PARENT/GUARDIAN EVERY 24 MONTHS.

Print Name: ______________________ **Signature:** ______________________

Date: ____________ **Relationship:** ______________________ **E-mail:** ______________________

Registration Number: ______________________
Assigned by SCPD

Date to be removed from CAD: ______________________
Entered by ITS

Send completed forms or Change of Status to:
Suffolk County Police Department • 30 Yaphank Avenue • Yaphank, NY 11980 • ATT: Public Information Office