POLICE DEPARTMENT COUNTY OF SUFFOLK, NY **SPECIAL NEEDS/SILVER ALERT PROGRAM**

ACCREDITED LAW ENFORCEMENT AGENCY **PDCS-8060d** 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:** _____ **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.)

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, and Police) 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, ADDRESS ALERTS MUST BE RENEWED EVERY 24 MONTHS.

Print Name: _____ **Signature:** _____

Date: _____ **Relationship:** _____ **E-mail:** _____

Registration Number: _____ **Date to be removed from CAD:** _____
Assigned by SCPD Entered by ITS

Send completed forms or Change of Status to:
Suffolk County Police Department **ATT: Community Outreach Bureau**
30 Yaphank Avenue, Yaphank, NY 11980 **Special Needs Coordinator**

Visit us Online at: **www.suffolkpd.org**
Crime Stoppers Confidential Tip Hotline: **1-800-220-TIPS**
Non-Emergencies Requiring Police Response: **(631) 852-COPS**

RESET