# Elder/ Adult Police Alert Registration

This form is intended to be filled out by the primary caregiver of a person who may wander from his or her home. This information will be kept confidential and will only be used to assist the police and others who may have to search for the person. **Please complete this form and bring it to your local police department.**

*Note: A recent photo of the person is required to complete this registration.*

Last Name

Middle

First Name

**Official Use Only**

If the individual frequents a Senior Center, Adult Day Care Center, or lives in a Nursing Home or Assisted Living Facility, please fill out the following.

Agency Name _____

Agency Contact Person _____

Phone Number _____

Partners in CaRIng

HELPING RHODE ISLAND FAMILIES CARE FOR ELDERS

# 1 Individual Information

**Name:** _____
First Middle Last

**Address:** _____
Street

_____, ____ _____
City ST Zip

Attach Recent Photo Here

**Date of Birth:** __ __ / __ __ / __ __ __ __

**Height:** _____ **Weight:** _____

**Eye Color:** _____ **Hair color:** _____

**Ethnicity:** _____

**Complexion:** ☐ Fair ☐ Medium ☐ Dark

**Primary language:** _____

**Distiguishing Characteristics:**
*Check All That Apply*

☐ Glasses ☐ Contacts ☐ Hearing Aid ☐ Wig

☐ Beard ☐ Mustache ☐ Balding

## Additional Characteristics

**Distinguishing Features:**
*Describe location if applicable*

Moles / Birthmarks: _____
Tatoos: _____
Left Handed / Right Handed: _____
Scars: _____

**Adaptive Equipment:**
*Check All That Apply*

☐ Cane ☐ Walker ☐ Crutches ☐ Wheelchair

**Additional information:** _____

_____

**If the individual drives, please list the following information:**

License plate number: _____
Make, model, color and year of car: _____
Places the person is known to frequent: _____

_____

_____

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## 2 Medical Information

**Primary Care Physician:** _____

**Physician Phone Number:** _____

**Please list any conditions or diseases the individual has been diagnosed with:**

_____

_____

_____

_____

**Please list any medication with dosage that the individual takes:**

_____

_____

_____

_____

**Is the individual physically aggressive? If so, please explain.**

_____

_____

## 3 Primary Contact Information

**Name:** _____ **Home Phone:** _____

**Address:** _____

**Place of Employment:** _____

**Work Phone:** _____ **Cell Phone:** _____

**Relationship to individual:** _____

### Secondary Contact (If primary contact is not available)

**Name:** _____ **Home Phone:** _____

**Address:** _____

**Work Phone:** _____ **Cell Phone:** _____

**Relationship to individual:** _____

**Secondary Contact (If primary contact is not available)**

**Name:** _____ **Home Phone:** _____

**Address:** _____

**Work Phone:** _____ **Cell Phone:** _____

**Relationship to individual:** _____

# 4 Authorization to Release Information

I, _____, acting on behalf of _____,
*State Your Relationship to Individual*

_____ agree to share this information with the Police
*State Name of Individual*

Department of _____.
*City in which you are filing this form*

I understand that this information will be filed and kept confidential and used only for the purpose of identification and assistance related to "Alert Efforts," should they be necessary. This authorization can be withdrawn at any time and will expire one year from the date of signature.

**Individual Signature:** _____

**Authorized Representative:** _____

**Date:** _____ **Expiration:** _____

**I,** _____ **am the authorized representative of**
*State Your Name*

**this individual as noted by:**

Please Check if applicable:

☐ Durable Power of Attorney for:

☐ Healthcare ☐ Financial

☐ Legal Guardianship