

# *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

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 ELDERLY

Official Use Only

# 1

## Individual Information

Name: \_\_\_\_\_  
*First Middle Last*

Address: \_\_\_\_\_  
*Street*

\_\_\_\_\_  
*City ST Zip*

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:

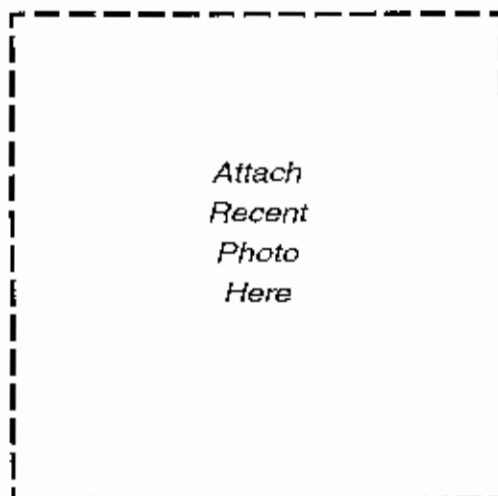
License plate number: \_\_\_\_\_

Make, model, color and year of car: \_\_\_\_\_

Places the person is known to frequent: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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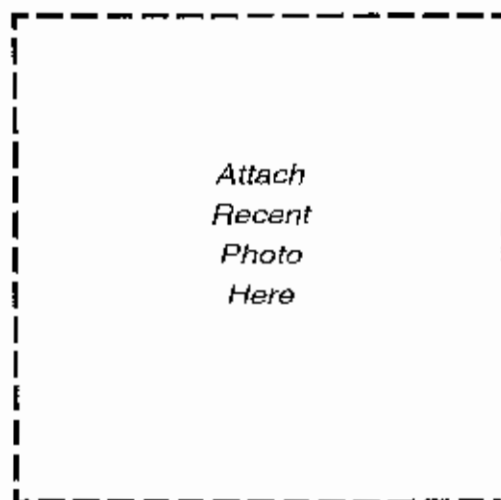
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\_\_\_\_\_

\_\_\_\_\_



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## *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.

\_\_\_\_\_  
\_\_\_\_\_

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## *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: \_\_\_\_\_

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***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 filling 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