**ALLAN W. FUNG**
MAYOR

**COLONEL MICHAEL J. WINQUIST**
CHIEF OF POLICE

**DEPARTMENT OF POLICE**
5 GARFIELD AVENUE
CRANSTON, RHODE ISLAND 02920
Phone (401) 942-2211 TDD 943-1410
Fax (401) 943-7750

The Cranston Police Department would like your help with implementing a program to help identify homes of children with Autism and Intellectual Disabilities (ID).

The goal of the program is to improve the safety of your children if/when they have interaction with police. The first step of this program would be to identify the addresses of the children. The addresses will be shared with the police department in an effort to provide officers with information prior to their arrival. This information will be voluntarily shared and kept confidentially within the Cranston Police Department. This program would help the officers to minimize the possibility of creating distress for the children and create a more positive police interaction.

Please indicate if you are interested in this program and complete the information below.

Yes: _____ No: _____

Child's Name: _____ D.O.B._____

Address: _____

Parent's Name: _____

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# Student Emergency Biographical Information

A registry to assist persons-at-risk

Last Name: _____ First Name: _____

## Personal Description

Date of Birth: _____ Sex: _____ Race: _____

Height: _____Weight: _____

Hair Color: _____Eye Color: _____

Glasses: _____

Diagnosis:

_____

_____

## Address Information:

Home: _____

School: _____

Physician: _____

Phone: _____

## Emergency Contacts

Name_____ Relationship _____

Address: _____

Phone Number: _____ Cell: _____

E-Mail: _____

Primary Hospital: _____

## Additional Information

Allergies:
_____

Verbal _____ Non Verbal _____
If non-Verbal, preferable mode of communication
(E.g. Sign, Pictures, word approximations):
_____
_____

Ambulatory _____ Non Ambulatory _____

Describe medical alert ID or other identifying information carried or worn:
_____
_____

Describe favored places your child might wander to:
_____
_____

Will your child respond to his/her name? _____

Does your child/family use a password? _____ If so, What: _____

Important information that will help assist personnel to communicate, understand, care for and maintain the safety of this person. (If necessary, attach a separate page.)

_____
_____

## RELEASE

**I, _____ voluntarily give my permission to the City of Cranston to retain and distribute this information to first response personnel for the sole purpose of identification and assistance to the person-at-risk. It will be kept confidential within the Cranston Police Department. I hereby waive any HIPPA claims that may exist upon the release of the information on this form.**

**Print Name: _____**

**Signature: _____**

**Date: _____**

Please return to: Lieutenant Jamie Jennings
Cranston Police Department, 5 Garfield Avenue Cranston, RI 02920
jjennings@cranstonpoliceri.com

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**COMPLETE THIS FORM ONLY TO IF YOU WISH TO WITHDRAW FROM THIS VOLUNTARY PROGRAM**

## Emergency Medical Information Program Withdrawal

I, _____, DOB _____, am voluntarily withdrawing from the Cranston Police Department's Emergency Medical Information Program and request all information used by the Cranston Police that pertains to me for the sole purpose of this program, be deleted. I release and discharge the City of Cranston, its successors, subsidiaries, employees, officers, directors and agents for all claims, liabilities, demands, and causes of action known or unknown, fixed or contingent, which I may have or claim to have against the City of Cranston as a result of this withdrawal and do hereby agree not to file a lawsuit to assert such claims.

Name (printed):_____

Address: _____

Signature: _____ Date: _____

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