Caring Hands - A Naperville Public Safety Program

Participant Information Form

This form requires a signature on the last page and may be filled out by the individual with the specific need, their parent/guardian, foster family, legal representative, or legal guardian. Submitting this form is voluntary, but please provide all the details that you can, using additional paper if necessary and attaching it to this form.

Participant's Information

Last Name: ____________________________________ First Name: _________________________ M.I.: _____

Nickname: ____________________ Date of Birth: _____________ Sex: ☐ Female ☐ Male Race: _________

Home Address: ____ Zip: _____________

Home Phone: _______________ Cell Phone: _______________ Email: _________________________________

Physical Description

Height: _____Ft. _____In. Weight: ____________ Hair Color: ______________ Eye Color: ______________

Distinguishing marks, scars, tattoos, etc. (*Describe and Location*)

Does Participant wear an ID bracelet or alert band? ☐ Yes ☐ No

If "Yes", type and location worn: ____

Employment and/or Educational Facility

Facility: ____ Contact Person: ___________________________

Address: ____ Phone: ____________________

Special Needs/Impairment/ Medical Condition

☐ Alzheimer's ☐ Autism ☐ Dementia ☐ Down Syndrome ☐ Epilepsy ☐ ______________________

☐Hearing Impairment ☐ Mobility Impairment ☐ Visual Impairment ☐ ___________________________

☐Mental Health Issue: ____

☐Medical Condition:

Does Participant use any electrically powered medical equipment? ☐ Yes ☐ No

If "Yes" what type is used <u>and</u> for what purpose is it required: ____

Does Participant require 24 hours use of the electrically powered medical equipment? ☐ Yes ☐ No

Does the electrically powered medical equipment have a battery backup? ☐ Yes ☐ No

**** The Naperville Fire Department strongly recommends Individuals dependent on electrically powered medical equipment due to life-threatening medical conditions, consider providing themselves with some type of back-up power supply in order to limit the potential impact of electrical power outages.**

Ability to communicate:

Spoken - ☐ None ☐ Poor ☐ Fair ☐ Good

Written - ☐ None ☐ Poor ☐ Fair ☐ Good

Ability to understand directions:

Spoken - ☐ None ☐ Poor ☐ Fair ☐ Good

Written - ☐ None ☐ Poor ☐ Fair ☐ Good

Any special communication and or compliance needs? ☐ Yes ☐ No

If "Yes" explain: ____

Primary Language: ____

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List any Medication(s):

Full Name of Medication	Full Name of Medication	Full Name of Medication
___________________________	___________________________	___________________________
___________________________	___________________________	___________________________
___________________________	___________________________	___________________________
___________________________	___________________________	___________________________

Location of an up to date list of medications in the residence:_______________________________________

Attending Physician: ________________________________ Phone: ________________________________

<u>Vehicle(s) Associated with Participant</u>

Year: _______ Make: __________________ Model: __________________ Color: ________________

License Plate#: ______________ State: ______

Year: _______ Make: __________________ Model: __________________ Color: ________________

License Plate#: ______________ State: ______

Year: _______ Make: __________________ Model: __________________ Color: ________________

License Plate#: ______________ State: ______

<u>Additional Information</u>

Favorite attraction, favorite spot where Participant may be found if missing:

Triggers or actions by others to avoid, if possible, that could upset/disturb the Participant:

Strategies and/or needs for positive interaction:

Any other information you feel we should know:

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Emergency Contact Information/Responsible Party

Primary Contact: ________________________________ Relationship: ______________________________

Home Address: ___________________________________ City, State, Zip: ________________________

Home Phone: _________________ Cell Phone: _________________ Work Phone: ________________

Email: ____

Secondary Contact: _______________________________ Relationship to Client: ______________________

Home Address: ___________________________________ City, State, Zip: ________________________

Home Phone: _________________ Cell Phone: _________________ Work Phone: ________________

Email: ____

Additional Contact: ________________________________ Relationship to Client:_____________________

Home Address: ___________________________________ City, State, Zip: ________________________

Home Phone: _________________ Cell Phone: _________________ Work Phone: ________________

Email: ____

Important: Please review the following before completing, signing, and/or submitting this form:

If you choose to complete this form, it will be added to the Naperville CAD Alert System. The 911-Dispatchers can relay this information to Public Safety Personnel in advance. I authorize the dissemination of the provided information above to Public Safety Personnel by 911 Dispatchers.

__________ Initials Required

Submitting this form is voluntary. This form requires a signature below and may be filled out by the individual with the specific disability, their parent/guardian, foster family, legal representative, or legal guardian. A signature is required to process the information contained on this form. It is the responsibility of the individual completing this form to update it immediately when changes occur, such as, but not limited to: address, contact information, or physical appearance. **It is required that an update be done at a minimum of once a year, on the individuals birthday**.

__________ Initials Required

The information gathered as part of Caring Hands program shall remain strictly confidential. The information shall be used only to provide assistance to emergency medical and police responders. No public safety worker shall knowingly violate this confidentiality clause. Except for willful or wanton misconduct, a public safety agency shall not be subject to civil liabilities for duties relating to the reporting of special needs individuals. Participation in the program will not result in preferential treatment.

__________ Initials Required

Name of Person Completing this Form: ____

Relationship to Participant: ____________________________________

Signature: ______________________________________ Date: ______________

Photo submitted with this registration form? ☐ Yes ☐ No

Additional pages included with this Participant Information Form? ☐ Yes ☐ No

Submit completed form to: **Naperville Police Department**
Caring Hands - Jim Pacetti
1350 Aurora Ave.
Naperville, IL 60540