

Special Needs Information Page (SNIP)

Date

Fill out both pages of this form.

Be sure to keep the information up to date. Make changes as needed.

Keep copies on hand in case of an emergency (at home, at school, at work, in the car, purse, backpack, etc.).

Confidential Information about the Person with Special Needs

Age

Last Name

First Name

Initial

Nickname (if any)

Date of Birth

☐

Male

☐

Female

Hair Color

Eye Color

Height

Weight

Race

Diagnosis/Disability

Suggestions for approaching and calming this person

**Attach a
Recent Photo
Here**

Identification-type
photo or school photo that
clearly shows the person's
facial features

Identifying Features (scars, moles, etc.)

Identification on Person (ID bracelet, necklace, tags, locator device, photo ID, etc.)

Person's Home Address

Address

Apt.

Does the individual live alone?

☐

Yes

☐

No

City

State

ZIP

This is a:

☐

Family home

☐

Group home

Home Phone

Cell Phone

Behavioral Information

Describe any behaviors or characteristics that may attract attention or endanger this person

Other important information or suggested accommodations

Does the person tend to wander away or elope?

☐

Yes

☐

No

☐

Sometimes

Favorite Attractions/Locations where person may be found

Communication Information

Primary Language

Second Language

How to Communicate with the person if he/she is non-verbal or low-verbal (picture cards, sign language, written words, communication device, etc.)

Medical Information

Please check all the special need(s) and any medical condition(s) that apply. Write in any other condition(s).

- | | | | | |
|---|---|--|---|--|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Autism Spectrum | <input type="checkbox"/> Asperger Syndrome | <input type="checkbox"/> Attention Deficit | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Emotional Disturbance |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Obsessive-Compulsive | <input type="checkbox"/> Oppositional Defiant |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Stroke | <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Visual Impairment |

Other Condition(s)

Doctor's name

Phone

Medication(s) and Dosage

Allergies to Medication:

Medical, Dietary, Sensory Issues and Requirements

Medical Devices or Equipment Used (oxygen, etc.)

Emergency Contact Information

Contact Person(s)

☐ Parent(s)

☐ Guardian/Caregiver

Address

Apt.

☐ Other Relationship

City

State

ZIP

Home Phone

Cell Phone

Email Address

Other information about emergency contact person(s)

Alternate Emergency Contact Information

Contact Person(s)

☐ Parent(s)

☐ Guardian/Caregiver

Address

Apt.

☐ Other Relationship

City

State

ZIP

Home Phone

Cell Phone

Email Address

I authorize the release of this information to law enforcement personnel/first responders to help identify and assist me, my family member, ward, conservatee or client during an emergency. I understand that completion of this form is voluntary and does not guarantee any special treatment. I acknowledge that I am responsible for the accuracy of the information and for updating the information when it changes.

Name of person completing this form

Signature of Person completing form

Date

Blank copies of this Special Needs Information Page are available at www.BeSafeTheMovie.com