Special Needs Information Page (SNIP)

Date

For best results, download and open this form in Adobe Acrobat Reader.
Fill out both pages by typing directly into the input fields or print it out and write by hand. Use up to date information.
Keep copies available 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).

☐ Alzheimer's	☐ Autism Spectrum	☐ Asperger Syndrome	☐ Attention Deficit	☐ Bipolar Disorder
☐ Cerebral Palsy	☐ Developmental Disability	☐ Diabetes	☐ Down Syndrome	☐ Emotional Disturbance
☐ Epilepsy	☐ Hearing Impairment	☐ Learning Disability	☐ Obsessive-Compulsive	☐ Oppositional Defiant
☐ Schizophrenia	☐ Seizure Disorder	☐ Stroke	☐ Traumatic Brain Injury	☐ 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 (SNIP) are available at www.BeSafeTheMovie.com