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

Photo Date ______________

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

Alzheimer's Disease	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 are available at www.BeSafeTheMovie.com