CANTON POLICE DEPARTMENT 45 River Road, Canton, CT 06019 911-Emergency / 860-693-0221 - Non Emergency

DEMENTIA/ALZHEIMER'S REGISTRY

IMPORANT: PLEASE INCLUDE A PHOTO OF THE INDIVIDUAL

PATIENT CONTACT INFO: Name _____ First Last Middle Address _____ Town Street State **PERSONAL IDENTIFIERS:** DOB _____ Last 4 Soc Security# ***-**-__ __ __ Height _____ Weight ____ Eye Color ____ Hair Color ____ Scars/Marks/Tattoos _____ Glasses? Y/N Hearing Aids? Y/N Other disabilities? (explain) Nicknames/Maiden Names _____ **MEDICATIONS/MEDICAL HISTORY: Critical Medications Critical Medical Conditions EMERGENCY CONTACT PERSON(S):** Name Address Telephone # ____Name Telephone# Address

FORMER ADDRESSES/"HANG OUTS" (Tell us about your Loved One)		
DOES YOUR LO	VED ONE HAVE ACCESS	S TO A VEHICLE, OR ALTERNATIVE
MODE OF TRAN	SPORTATION?	
If so, please provide	e the any pertinent information	on (Make, Model, Year, Color, License Plate#):
I (signer) authorize	the release of the aforementi	oned information to the Canton Police
Department and the	members thereof to hold for	use in the event of an emergency to assist in
locating the aforeme	entioned individual should th	ney wander, become lost, or missing. I
understand that the	use of such information will	be for professional purposes only and may be
distributed to other	town employees/agents who	may be utilized in an emergency search/rescue
operation. I also un	derstand that some descripti	ve information may be released to the press if
deemed appropriate	by police personnel to assis	t in safely located said person. I agree to hold
harmless all Town of	of Canton Employees and ag	ents thereof who utilize the aforementioned
	n in the course of their profe	
Name	Signature	Date
Witness	Signature	Date