



At-Risk Resident Recognition Program Enrollment Form

PLEASE ATTACH PHOTO

Parents or Guardians should update this form annually.
Completed forms should be returned to:
Hillside Police Department
425 Hillside Ave, Hillside, IL, 60162,
or emailed to: arr@hillside-il.org

Name of Person with Disability: _____ Nickname: _____

Home Address: _____ Home Telephone: _____

Date of Birth: _____ Sex: _____ Height: _____ Weight: _____ Hair: _____ Eyes: _____

Identifying Marks or Features: _____

Identification Worn (Medic alert, GPS, Clothing tags, Etc.): _____

Cognitive ability: High Average Low Communication: Verbal Non-Verbal

Best Method of Communication: _____

Medical Condition(s): _____ Current Medications: _____

Medication or Food Allergies: _____

Sensory Issues (circle all that apply): Touch Sight Sound Smell Balance Other: _____

Triggers/Fears: _____ Calming Methods _____

Does the Individual Wander?: Yes No Location of Past Wanderings: _____

Places of Interest or Activities: _____

School or Life Enrichment Program: _____ Address _____

Phone: Home: _____ Cell: _____ Other: _____

Parent/Guardian: _____ Email: _____

Address: _____

Phone: Home: _____ Cell: _____ Other: _____

Emergency contact: _____ Address _____

Phone: Home: _____ Cell: _____ Other: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, am the parent or legal guardian of the individual referenced above as a person at risk, have voluntarily provided the information listed above and hereby authorize the release of all such information for purposes of identification of, or assistance to, the person at risk to any first responder, law enforcement personnel, dispatchers and/or employees of representatives of the Village of Hillside and agree to indemnify them and hold them harmless from all liability for damages arising from the use of such information for the specified purposes.

Internal Use Only: Date Entered: _____ CFS: _____