

Registration Form



STAFFORD POLICE SPECIAL NEEDS REGISTRY

The **Stafford Township Special Needs Registry** is a **voluntary** service open to all citizens with disabilities who reside, attend school, or are employed in Stafford Township. The registry was created to help police officers and other emergency personnel, better assist residents with special needs in the event of an emergency by providing those first responders with vital information regarding a registrant's disability, emergency contact information, physical description, and current photograph.

First Name (required) _____ Last Name (required) _____

Middle Initial _____ Nickname (if any) _____

Home Address (required) _____

City, State and Zip (required) _____

Driver's License state _____ Driver's License Number _____

Email address _____

Home Phone # (required) _____ Cell Phone # (required) _____

Person Filling Out This Form (If Different from Above)

First Name _____ Last Name _____

Relationship to registrant _____

Registered Vehicles

Does the registrant own or frequently drive a vehicle? Yes No

Vehicle Plate State _____ Vehicle Plate # _____ Vehicle Plate State _____ Vehicle Plate # _____

Registrant Identifiers

Date of Birth (required) _____ Gender (required) Male Female Other _____

Height (required) (ft.) _____ (Inches) _____ Weight (in pounds) (required) _____

Build (required) _____ Hair Color (required) _____ Eye Color (required) _____

Corrective Lenses: Contact Lenses Eye Glasses Prescription Sunglasses

Corrective Prescription Information: _____

Description of Eyeglasses: _____

Scars/Piercings/Marks/Tattoos (eg: tattoo of heart on right forearm): _____

Communication

Method of Communication (required)

Augmentative/Speech Assistance Device Non-Verbal Verbal Sign Language Written

What type of Augmentative/Speech Assistance Device does the registrant use? _____

What type of sign language does the registrant use? _____

What language(s) does the registrant speak or understand? (required) _____

Registrant School / Employment Information

Does the registrant attend school or are they employed? (required) Yes No

Name of School / Employer: _____

School / Employer Address: _____

School / Employer City, State and Zip: _____

School / Employer Phone # _____ Contact: _____

(Additional School / Employer)

Name of School / Employer: _____

School / Employer Address: _____

School / Employer City, State and Zip: _____

School / Employer Phone # _____ Contact: _____

Please attach or list additional Schools / Employers in the additional information area

Special Needs

What is the registrant's special need? (required) (You may select more than one)

- | | |
|--|--|
| <input type="checkbox"/> Alzheimers / Dementia | <input type="checkbox"/> Mobility Impairment: Crutches |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Mobility Impairment: Wheelchair |
| <input type="checkbox"/> Diabetes / Hyperglycemic (Type _____) | <input type="checkbox"/> Mobility Impairment: Other _____ |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Obese |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Oxygen Dependent |
| <input type="checkbox"/> Electricity Dependent | <input type="checkbox"/> Project Life Saver |
| <input type="checkbox"/> Hard of Hearing / Deaf, or other Hearing Impairment | <input type="checkbox"/> PTSD (Post-Traumatic Stress Disorder) |
| <input type="checkbox"/> I/DD - Intellectual / Developmental Disability | <input type="checkbox"/> Service Animal |
| <input type="checkbox"/> Life Alert | <input type="checkbox"/> Sight Impairment / Blind |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Speech Impairment |
| <input type="checkbox"/> Other _____ | |

Describe any of the registrant's life threatening medical concerns: (eg. food or medicine allergies, seizures, etc.) _____

Does the registrant use an Epi-pen? (If yes, please give location where it is stored) Yes No

Any Triggers which affect the registrant? (i.e., Loud Noises, Bright Lights) _____

Any Calming Methods used for the registrant? _____

Does the registrant frequent / gravitate to water, playgrounds, etc.? (If yes, give locations) Yes No

What products / equipment and with which vendor does the registrant have from Life Alert / Project Life Saver? (eg. pendant, wristband, mobile app, push HELP button, etc.) _____

Does the registrant have a Social Worker / Case Worker assigned? Yes No

Name of Social Worker / Case Worker _____ Phone # _____

Does the registrant have a service animal? Yes No

If yes, give the type/description, name and what the service animal assists with _____

If the registrant has a wheelchair, what type? Manual Motorized

Any other information that may be important? _____

Does the registrant live alone? Yes No If no, please list with whom registrant resides: _____

If yes, registrant may provide information to assist First Responders with gaining emergency access to residence (i.e.; code to garage door, alarm, where key is hidden outside of residence, etc.) _____

Emergency Contact Information

First Name (required) _____ Last Name (required) _____

Address (required) _____

City, State and Zip (required) _____

Home Phone # (required) _____ Cell Phone # (required) _____

Relationship to the registrant (required) _____

Is this person the Legal Guardian of the registrant? Yes No

Additional Emergency Contact Information

First Name (required) _____ Last Name (required) _____

Address (required) _____

City, State and Zip (required) _____

Home Phone # (required) _____ Cell Phone # (required) _____

REGISTRANT PICTURES - If you are mailing this form, please attach by paper clip or staples as many pictures of the registrant that you feel are necessary. If you are scanning and emailing, please email the picture(s) as an attachment.

Acknowledgement

I acknowledge that by checking the box below that the information being provided is truthful, current and valid and that I am authorized to submit it on my own behalf or as the legal guardian with authority to submit it on behalf of another. I further understand that by enrolling myself or someone else in the Stafford Township Special Needs Registry that the personal information entered may be used by emergency personnel, including, but not limited to, law enforcement officers, emergency medical services (first aid/paramedics), and fire department personnel in the event of a personal emergency or other emergency situation. I also acknowledge that it will be my responsibility to keep the information on the registry up-to-date.

It is further understood that completion of this form and participation in the Stafford Township Special Needs Registry is voluntary and cannot guarantee and is not intended to convey and warrant, either express or implied, as to outcomes, promises, or benefits from the use of this form and participation in this program. Use of the Stafford Township Special Needs Registry constitutes acknowledgement and acceptance of these limitations and disclaimers.

I understand the above disclaimer (required) Yes No

(Signature of the person filling out this form)

(Date)

Please complete all pages of this application, scan and email along with your pictures to:

specialneedsregistry@staffordpolice.org

If you prefer to mail the application along with the pictures, send to:

Stafford Township Police Department

Attn: Special Needs Registry

260 E. Bay Avenue, Manahawkin, NJ 08050