Special Needs Fact Sheet
A safety tool for emergency situations

Confidential Information about Person with Special Needs Date: _____

_____ _____ ____ _____
Last Name First Name Initial Nickname (if any)

Date of Birth: _____ Age:_____

Male Female

Hair Color: _____ Eye Color: _____

Height:_____ Weight_____

Race: _____

Diagnosis/Disability: _____

Identifying Features (scars, moles, etc.)

_____

_____

Identification on Person (ID bracelet, necklace, tags, locator device, other device):

_____

_____

Attach
Recent Photo Here

(Identification-type photo
or school photo
clearly showing the person's
facial features)

Photo Date: _____

Suggestions for approaching person and de-escalation techniques:

_____

_____

Home Address

Address: _____Apt._____ Does the individual live alone? Yes No

City: _____ St: _____ ZIP: _____ Is this a Family home Group home

Home Phone: _____ Cell Phone: _____

Emergency Contact Information

Contact Person(s): _____ Parent(s) Guardian/Caregiver

Address: _____Apt._____ Other Relationship _____

City: _____ St: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Email Address (not for emergency use): _____

Does this person have a conservatorship (full or partial?) Yes No

Continued on other side

Behavioral Information

Does this person tend to wander off or elope? Yes No Sometimes

Favorite Attractions/Locations where person may be found: _____

Describe any behaviors or characteristics that may attract attention or endanger this person:

_____

Other important information or suggested accommodations:

_____

_____

Alternate Emergency Contact Information

Contact Person(s): _____ Parent(s) Guardian/Caregiver

Address: _____Apt. _____ Other Relationship _____

City: _____ St: _____ ZIP: _____

Phone: _____ Cell Phone: _____

Communication Information

Primary Language: _____ Second Language: _____

Communication Method if non-verbal/low-verbal (picture cards, sign language, written words, communication device):

_____

Medical Information

Please indicate the nature of the special need(s) and any medical condition(s) that may apply:

Alzheimer's Disease	Autism/Asperger Syndrome	Bipolar Disorder	Cerebral Palsy	Diabetes
Developmental Disability	Oppositional Defiant Disorder	Down Syndrome	Emotional Disturbance	
Hearing Impairment	Epilepsy Schizophrenia	Seizure Disorder	Visual Impairment	

Other Condition(s)_____

Physician Contact: _____ Phone: _____

Physician Contact: _____ Phone: _____

Medication(s) and Dosage: _____

_____

Medical, Dietary, Sensory Issues and Requirements:

_____

Medical Devices or Equipment Used: _____

I authorize the release of this information to emergency personnel for official use to help identify and assist me, my family member, ward or client during an emergency. I understand that this form is a tool, and that completion of this form is voluntary and does not guarantee any special treatment by first responders. 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