

SPECIAL AWARENESS VERIFICATION ENROLLMENT

Name						Date			Photo Included	Yes	No		
Address						Phone							
Primary Condition						DOB			Age				
Medication(s)						Presently taking meds as directed?		Yes	No				
Physician						Preferred Hospital							
Sex		Race		Height		Weight		Hair		Eyes		Scars/Marks	
Education	1-5 grade	6-8 grade	9-12 grade	Some college	Associates Degree	Bachelor Degree	Graduate Degree						
Marital Status	Single	Married	Widowed	Divorced	Cohabiting	Dating/Engaged	Name:						

(Additional pages may be attached if needed.)

CONDITION(S)	MEDICATIONS	PHYSICIAN/HOSPITAL	
Symptoms			
Concerns/Awareness			
How can emergency responders assist or deescalate situations involving this family member?			
Is there any additional information that will aid responders in meeting the unique needs of this individual?			
Are there any behaviors or trigger words that should be avoided when assisting this individual?			
What are some topics that deescalate this individual? (Talking about favorite food, TV show, family members, activity, sport, etc.)			
SAFETY INFORMATION			
	Are there any weapons in the home?		
	If so, what kind and how many weapons?		
	Does this individual use or have a history of abusing alcohol and/or drugs?		
	If so, explain.		
	Not including the individual, are there any children living in the home?		
	Does the individual have a history of physically harming members of the household?		
	Does the individual have a history of physically harming others?		
	Does the individual have a history of physically harming his/herself?		
CAREGIVERS			
	Name	Phone	Relationship
1.			
2.			
3.			

