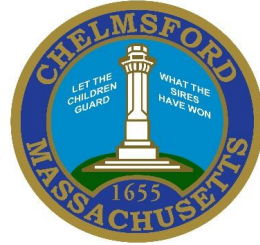




CHELMSFORD POLICE DEPARTMENT SAFE WATCH PROGRAM APPLICATION



APPLICATION ALSO AVAILABLE ONLINE AT CHELMSFORDPD.COM

CONFIDENTIAL & VOLUNTARY

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____

PHONE #1: _____ PHONE #2: _____

DATE OF BIRTH: _____ SSN: _____

NICKNAME(S): _____

PHYSICAL CHARACTERISTICS

HEIGHT: _____ WEIGHT: _____ EYES: _____ HAIR: _____ RACE: _____

IDENTIFYING CHARACTERISTICS (TATTOOS, BIRTHMARKS, JEWELRY, TAGS, AND MEDICAL ALERT BRACELETS):

MEDICAL CONDITIONS (CHECK ALL THAT APPLY):

____ AUTISM ____ HEARING IMPAIRMENT ____ NON-VERBAL ____ SEIZURES

____ COGNITIVE DISABILITY ____ DEVELOPMENTAL DISABILITY ____ MENTAL HEALTH ISSUES

____ VISION IMPAIRMENT ____ BRAIN INJURY ____ PHYSICAL DISABILITY

____ OTHER (PLEASE SPECIFY):

KNOWN DIAGNOSIS:

PREVIOUS HOSPITALIZATIONS: ____ YES ____ NO

IF SO, WHEN _____

WHERE _____

OTHER MEDICAL ISSUES:

PRESCRIPTION OR OVER THE COUNTER DRUGS BEING USED:

DIETARY/EATING ISSUES (I.E. HYPERGLYCEMIC, INSULIN DEPENDENT, ALLERGIES):

IS THERE ALCOHOL OR ILLEGAL DRUG USE? _____

HOW FREQUENTLY? _____

ARE THERE TRIGGERS FOR THIS BEHAVIOR?

ARE THERE GUNS IN THE RESIDENCE? _____

OTHER WEAPONS? _____

DOES THE PERSON HAVE ACCESS TO THESE WEAPONS OR OTHER WEAPONS?

HAS THERE BEEN PAST VIOLENCE EXHIBITED TOWARDS OTHERS OR ANIMALS? IF SO, WHEN AND HOW?

HAS THE PERSON ATTEMPTED SUICIDE? IF SO, WHEN AND HOW?

DISTINGUISHING BEHAVIORS AND SIGNS OF DISTRESS (I.E. PARANOIA, HALLUCINATIONS):

DOES THE PERSON HAVE SENSORY ISSUES? (I.E. LOUD NOISES, LIGHTS, TOUCHING):

IS THE PERSON LIKELY TO WANDER AWAY? IF SO, WHERE HAVE THEY GONE BEFORE? WHO MAY THEY VISIT?

EFFECTIVE APPROACHES AND DE-ESCALATION TECHNIQUES:

FAVORITE PLACES, ATTRACTIONS, ACTIVITIES, PETS, HOBBIES, TOPICS, SPORTS, FOODS, ETC:

PREFERRED COMMUNICATIONS METHODS (I.E. IF NON-VERBAL – SIGN LANGUAGE, PICTURES, PRINTED WORDS – OR PREFERRED LANGUAGE):

GREATEST CONCERNS YOU HAVE AS A CARETAKER:

PROFESSIONALS WORKING WITH THE PERSON:

NAME: _____ SPECIALTY: _____

ADDRESS: _____

PHONE #: _____

NAME: _____ SPECIALTY: _____

ADDRESS: _____

PHONE #: _____

NAME: _____ SPECIALTY: _____

ADDRESS: _____

PHONE #: _____

EMERGENCY CONTACTS:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE #: _____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE #: _____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE #: _____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE #: _____

COMPLETED BY:

OFFICER: _____ DATE: _____

NAME OF CARETAKER COMPLETING FORM:

ONCE THIS FORM HAS BEEN COMPLETED, PLEASE BRING IT TO THE CHELMSFORD POLICE DEPARTMENT OR EMAIL IT TO OFFICER AIDAN GILLIS – AGILLIS@CHELMSFORDMA.GOV. PLEASE PROVIDE A RECENT PHOTOGRAPH OF THE PERSON BEING ENROLLED IN THE PROGRAM.

IF ANY INFORMATION NEEDS TO BE UPDATED, PLEASE CALL THE CHELMSFORD POLICE DEPARTMENT AT 978-256-2521 OR EMAIL OFFICER GILLIS. THANK YOU.

For Police Department Use

ENTERED INTO PROIV _____

PLACED IN BINDER _____

UPDATED: _____ UPDATED: _____

UPDATED: _____ UPDATED: _____