CITY OF BOLIVAR

DEMENTIA & ALZHEIMER'S SAFETY REGISTRATION FORM

Voluntary safety information for authorized first responders

If someone is missing or in immediate danger, CALL 911. This form does not replace emergency reporting.

Do not include Social Security numbers, financial account numbers, or passwords.

1 PERSON'S IDENTITY & DESCRIPTION

Full legal name		**Preferred name / nickname**
Date of birth / approximate age	**Home address**	**City / state / ZIP**
Phone (if applicable)	**Preferred language**	**Other names / aliases**
Height / build	**Hair color / style**	**Eye color / glasses**
Skin tone / identifying description		**Scars / tattoos / birthmarks**
Mobility / hearing / vision aids		**Usual clothing / footwear**

2 DIAGNOSIS & COMMUNICATION

Condition / diagnosis (if known)	**Stage / support needs (if known)**
Response to their name / ability to give address	**Best way to approach / introduce yourself**
Communication or sensory needs	**Helpful words / gestures / signs**
Triggers, fears, or misunderstood behaviors	**What helps them feel calm / what to avoid**

3 WANDERING & MISSING-PERSON SAFETY

History of wandering / date of prior incidents	**Familiar places, routes, likely destinations**
Places / hazards to check first	**Known risks: traffic, water, falls, weather, etc.**
Phone use / rides with strangers (Yes / No / Sometimes)	**Transportation or vehicle description**
Reaction to uniforms, lights or sirens	**Safe approach / redirection / notification order**

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Medical, contact, identification, and consent details

4 MEDICAL INFORMATION — IMPORTANT FOR FIRST RESPONDERS

Primary doctor / clinic and phone	**Neurologist / specialist and phone**
Preferred hospital / relevant medical history	**Other major medical conditions**
Allergies and severity / reactions	**Medical devices / implants / sensory needs**
Current medications (name, dose, schedule; attach current list if needed)	
Recent changes / time of last dose	**Urgent alerts / responder treatment considerations**

5 EMERGENCY CONTACTS & LEGAL REPRESENTATIVE

1st contact: name / relationship	**Primary phone**	**Alternate phone / notes**
2nd contact: name / relationship	**Primary phone**	**Alternate phone / notes**
3rd contact: name / relationship	**Primary phone**	**Alternate phone / notes**
Guardian / health care proxy / authority (if any)	**Guardian / proxy phone**	
Do NOT contact / release information to (if legally applicable)		

6 PHOTO & IDENTIFICATION RESOURCES

Recent photo location / date taken	**Photo available to responding agency? Yes / No / Unknown**
Caregiver / registrant contact for photo retrieval; other photo source	

7 REGISTRATION, CONSENT & ADDITIONAL NOTES

Person completing form / relationship	**Phone / email / date completed**
Person's consent? Yes / No / Unable to provide	**Representative's legal authority / basis**
Additional information / instructions for first responders	

ACKNOWLEDGMENT: I confirm that, to the best of my knowledge, this information is accurate. I understand registration does not guarantee identification or response, and information should be handled under applicable law and agency policy.

Signature of person / authorized representative

Date

Receiving agency / date received / review date:

Review every 6–12 months and whenever medication, contacts, address, appearance, or care needs change.