

BOLTON POLICE DEPARTMENT

15 WATTAQUADOCK HILL ROAD BOLTON, MASSACHUSETTS 01740

Phone: 978-779-2276 Fax: 978-779-6079

AUTISM / ALZHEIMERS / WANDERER / COGNITIVE ISSUES ALERT FOR EMERGENCY RESPONSE

	Resident Information:
	NAME:
Attach recent photo here	Nickname (if any):
Head and Shoulder portrait type photo	D.O.B.:
if possible	Height:
	Weight:
Eye color: Hair	color:
Complexion:	
Identifying scars, marks or tattoos:	
Phone number (home)	
Parent/Guardian/Caretaker (name)	(ph#)
Emergency contact #1 (name)	(ph#)
Emergency contact #2 (name)	(ph#)
Is a Medical or Identification bracelet or device we	orn? Y or N (note location if Yes)
Any current prescription medications?	
Sensory Impairments? (sight, hearing, etc)	
Are they verbal? Y or N or Partially Langua	age spoken:
If non-verbal, method of communication used (sign	n language, written, picture boards, etc):

Any past history of, or tendency to Wander?		
f so, are there any favorite local destinations	s or types of places they will go to, that should be searched in the event they go	missing ^e
Do they drive? Y or N If so, vehicle des	cription & license plate number	
If they attend school or a day program, what	is the name and location of it?	
Medical Providers:		
Name:	(ph#)	
Name:	(ph#)	
Hospital/Clinic/Office name & address:		
Other pertinent info you wish to include:		
		
	Release Form	
	, grant permission to the Bolton Police Department to	retain
(print name)		retain
	on file, for the purpose of identification and assistance relative to ive Issues Alert efforts and related emergency investigative activities.	ities I
will notify the Bolton Police Departm	ent of any change or cancellation of this Alert Notification.	11103. 1
Signature	Date:	
Relationship to Individual:		
to maryidan.		
Please	e mail or drop off at the Bolton Police Department.	