Autism Alert Recognition Program
Enrollment Form

PLEASE ATTACH PHOTO

Parents or guardians should update this form annually.
Completed forms should be returned to the Woodridge Police Department:
1 Plaza Drive, Woodridge, IL, 60517,
Or emailed at: wpdadmin@vil.woodridge.il.us

Name of Person with Autism: _____ Nickname: _____

Home Address: _____ Home Telephone: _____

Date of Birth:_____ Sex: _____ Height: _____ Weight: _____ Hair: _____ Eyes: _____

Identifying Marks or Features: _____

Identification Worn (Medic alert, GPS, Clothing tags, Etc.): _____

Cognitive ability: High Average Low Communication: Verbal Non-Verbal

Best Method of Communication: _____

Medical Condition(s): _____ Current Medications: _____

Medication or Food Allergies: _____

Sensory Issues (circle all that apply): Touch Sight Sound Smell Balance Other: _____

Triggers/Fears: _____Calming Methods_____

Does the Individual Wander?: Yes No Location of Past Wanderings: _____

Places of Interest or Activities: _____

Parent/Guardian: _____ Email: _____

Address: _____

Phone: Home: _____ Cell: _____ Other: _____

Emergency contact: _____Address_____

Phone: Home: _____ Cell: _____ Other: _____

Emergency contact: _____Address_____

Phone: Home: _____ Cell: _____ Other: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____, am the parent or legal guardian of the individual referenced above as a person at risk, have voluntarily provided the information listed above and hereby authorize the release of all such information for purposes of identification of, or assistance to, the person at risk to any first responder, law enforcement personnel, dispatchers and/or employees of representatives of the Village of Woodridge and agree to indemnify then and hold them harmless from all liability for damages arising from the use of such information for the specified purposes.

Internal Use Only: Date Entered:_____ CFS:_____