MONROE POLICE DEPARTMENT
NO PERSON LEFT BEHIND

NAME OF PERSON WITH SPECIAL NEEDS_____

ADDRESS_____

DATE OF BIRTH_____ **SEX m**___ **f**__

HOME TEL #_____ **CELL#**_____

EMERGENCY CONTACTS (WHO SHOULD BE NOTIFIED IN THE EVENT OF EMERGENCY)

NAME_____ **RELATION**_____ **TEL#**_____

NAME_____ **RELATION**_____ **TEL#**_____

NAME_____ **RELATION**_____ **TEL#**_____

PHYSICIANS NAME_____ **TEL#**_____

HOSPITAL_____ **ADDRESS**_____

SPECIAL NEED OR DISABILITY_____

WHAT SERVICES WOULD YOU REQUIRE IN THE EVENT OF AN EMERGENCY OVER 48 HOURS TO MAINTAIN YOUR CURRENT HEALTH CARE NEEDS. INCLUDE ALL MEDICATIONS, OXYGEN NEEDS, DIALYSIS AND ANY HOME CARE NEEDS ON A DAILY BASIS. _____

_____

_____

_____

_____

_____

_____ _____ _____

PRINT NAME **SIGNATURE** **DATE**

_____ _____ _____

PRINT NAME OF LEGAL GUARDIAN **SIGNATURE** **DATE**

Please complete and return to the Village of Monroe Police Department