

# MEDICAL/MENTAL HEALTH REGISTRATION

NAME: \_\_\_\_\_ DATE FORM COMPLETED: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

- MALE
- FEMALE

PHYSICAL DESCRIPTORS: \_\_\_\_\_

SCARS/MARKS/TATOOS: \_\_\_\_\_

CONTACT NAMES:	E-MAIL	PHONE NUMBERS:	RELATIONSHIP:
----------------	--------	----------------	---------------

1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____

SENSORY ISSUE AND/OR MEDICAL CONDITION(S):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- AUTISM SPECTRUM
- DEVELOPMENTAL DISABILITY
- PHYSICAL DISABILITY
- NON-VERBAL
- DEAF
- BLIND
- ALZHEIMER'S DISEASE
- PRONE TO SEIZURES
- DEMENTIA
- MENTAL HEALTH CHALLENGES
- ACQUIRED BRAIN INJURY
- OTHER

CALMING TECHNIQUES:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FURTHER INFORMATION FIRST RESPONDERS MAY NEED TO KNOW:  
\_\_\_\_\_  
\_\_\_\_\_

MAY RUN FROM FIRST RESPONDERS: YES OR NO

