SENIOR SAFE PROGRAM

All Information Remains Confidential at 9-1-1

PARTICIPANT'S GENERAL INFORMATION

Last Name:	**First Name:**	**MI:**	
Address:	**City:**	**State:**	**Phone:**
Additional Telephone Numbers within the Residence:			
Date of Birth: (mm/dd/yyyy)	**Sex:**	**Race:** Select	
Height: Select	**Weight:** Select	**Hair Color:** Select	**Eye Color:** Select
Vehicle Information -	**Color:**	**Year:**	**Make:**
Model:	**License Plate No:**	**License State:**	
Special Needs or Considerations:			
Wheelchair: Yes ☐ No ☐	**Oxygen in Home:** Yes ☐ No ☐	**Pets:**	
Medical Information			
Doctor's Name:		**Phone:**	
Hospital Preference: Select		**Other:**	
Chronic Illness:			
Allergies:			
Medications:			
Check All That Apply: ☐**Visually Impaired** ☐**Hearing Impaired** ☐**Pacemaker** ☐**Asthmatic** ☐**Seizures** ☐**Mental Impairment** ☐**Mobility Impairment** ☐**Verbal Impairment** ☐**Diabetic** ☐**Other:**			
Funeral Information			
I have made prior funeral arrangements? Yes ☐ No ☐			
If yes, where?			

SENIOR SAFE PROGRAM

Emergency Contact Person Not Living With You			
Last Name:	**First Name:**		**MI:**
Address:	**City:**	**State:**	
Home Phone: ☐☐☐☐☐☐☐☐☐☐☐☐	**Work Phone:** ☐☐☐☐☐☐☐☐☐☐☐☐	**Key to Home:**	**Yes** ☐ **No** ☐
Relative's Information			
Name:	**Relationship:**		
Address:	**City:**	**State:**	
Home Phone: ☐☐☐☐☐☐☐☐☐☐☐☐	**Work Phone:** ☐☐☐☐☐☐☐☐☐☐☐☐	**Key to Home:**	**Yes** ☐ **No** ☐
Name:	**Relationship:**		
Address:	**City:**	**State:**	
Home Phone: ☐☐☐☐☐☐☐☐☐☐☐☐	**Work Phone:** ☐☐☐☐☐☐☐☐☐☐☐☐	**Key to Home:**	**Yes** ☐ **No** ☐
Neighbor's Information			
Name:	**Address:**		
Home Phone: ☐☐☐☐☐☐☐☐☐☐☐☐	**Work Phone:** ☐☐☐☐☐☐☐☐☐☐☐☐	**Key to Home:**	**Yes** ☐ **No** ☐

Please notify the Springfield Center for Independent Living at (217) 523-2587 if you need this information in an alternative format (Braille, Cassette Tape, etc.) or if you need help with filling out the form. If you like you may fax this form to the 9-1-1 Center at (217) 753-6372, ATTN: Mike Lopez.

I am voluntarily participating in the Senior Safe Program. I understand that this is a cooperative program involving the Springfield/Sangamon County area emergency service providers. I hereby authorize 9-1-1 Dispatch to disclose and release all information in this document to Emergency Service Providers.

Signature:_____ **Date:**_____

Witness:_____ **Date:**_____

ANY CHANGES TO THIS INFORMATION SHOULD BE REPORTED IN WRITING IMMEDIATELY TO:

Mike Lopez
Sangamon County E.T.S.D.
2000 Shale
Springfield, IL 62703

Office Use Only:	Date Received:		Date Entered:	