Special Needs Alert Program (SNAP)

☐ New Alert ☐ Updated Alert

Registrant Information

First Name: _____ Last Name: _____ MI: _____

_____
Physical Address City State Zip Code

Home Phone: ( ) _____ Cell Phone: ( ) _____

Primary Language Spoken: _____ Gender: ____Male ____Female

Date of Birth: (mm/dd/yyyy): _____ Name of School or Work: _____

*E-mail: _____ (**used for annual update alert reminders, etc.*)

Emergency Contact Information

First Name: _____ Last Name: _____ MI: _____

_____
Physical Address City State Zip Code

Home Phone: ( ) _____ Cell Phone: ( ) _____

Work Phone: ( ) _____ Relationship: _____

Special Needs (Please check all that apply)

_____ Visually Impaired	_____ Seizure Disorder	_____ Cognitively / Developmentally delayed
_____ Legally Blind	_____ Speech Impaired	_____ Mood Disorder/ Mental Illness
_____ Hearing Impaired	_____ Prosthesis	_____ Paralysis (full or part)
_____ Deaf	_____ Cerebral Palsy	_____ Parkinson's
_____ Immobile	_____ Down's Syndrome	_____ Alzheimer's / Dementia
_____ Non-verbal	_____ Muscular Dystrophy	_____ Autism Spectrum Disorder/Asperger Syndrome

_____ Other: _____

Special Considerations (Please check all that apply)

_____ Responds to verbal commands	_____ Responds well to touch	_____ Has high pain tolerance
_____ Communication/ Speech Delay	_____ Light/ Siren Sensitivity	_____ Wheelchair/ Walker/ Cane
_____ Communicates with PECS	_____ Sound Sensitivity	_____ Tendency to Wander
_____ Communicates with Sign Language	_____ Uses Hearing Aids	_____ Fascination with water
_____ Scared of fast movements/ crowds	_____ Color Sensitivity	_____ Tendency to hide

_____ Other: _____

Additional Comments: _____

The Special Needs Alert Program (SNAP) is designed to ensure the safety of those residents of the City of Winters that are most vulnerable to emergencies and disasters, the elderly and infirmed and those with various disabilities and special needs. The information you provide about health and medical conditions may be shared with Police, Fire and other emergency responders to assist them in responding to an emergency or disaster. You may revoke your consent to sharing information at any time by written request to: The City of Winters Police Department, 702 Main St., Winters, CA 95694 (ATTN: SNAP). Providing this information does not insure that emergency responders will be able to provide services to you in an emergency but will assist them in responding appropriately based on available resources. **I give local law enforcement and/or medical personnel permission to enter my home in case of an emergency. By submitting this information, I consent to sharing information on this form. I certify that the information provided on this form is true and correct. It is my responsibility to update the information on this form as needed.**

Name of Individual/Primary Care Giver/Responsible Party completing form: _____

Signature: _____ Date: _____

Relationship: _____

702 Main Street, Winters, CA. 95694 PHONE: (530) 795-2261 FAX: (530) 795-3921