

Post Falls Police Department
Special Needs Information Sheet

Please complete form in full, using back of page if needed to provide additional information.

Personal Information

Date: _____

Last: _____ First: _____ Mid: _____

Nickname or other names that your loved one may respond to: _____

Address: _____ City: _____

Home Phone: (_____) _____

DOB: _____ Sex: _____ Height: _____ Weight: _____

SSN#: _____ Eyes: _____ Hair: _____ Glasses: _____

Distinguishing marks/tattoos/scars/etc: _____

Medical/physical/mental conditions: _____

How will your loved one respond to people in uniform?: _____

Additional: _____

_____ Photo attached: ___ Date of photo: ___/___/___

Caregiver/Guardian Information

Last: _____ First: _____ Mid: _____

Address: _____ City: _____

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

Second Contact Person: _____ Phone: _____