LIVONIA POLICE DEPARTMENT

AUTISM / OTHER DISABILITIES
ENTRY REQUEST

DATE: _____

NAME OF INDIVIDUAL: _____ DATE OF BIRTH: _____

ADDRESS: _____ PHONE: _____

RACE: _____ SEX: _____ HEIGHT: _____ WEIGHT: _____ HAIR COLOR: _____ EYE COLOR: _____

DIAGNOSIS: _____

VERBAL: ☐ NON-VERBAL: ☐ ASSISTIVE TECHNOLOGY: _____

MOTHER: _____ MOTHER PHONE: _____

FATHER: _____ FATHER PHONE: _____

GUARDIAN NAME(S): _____ GUARDIAN(S) PHONE: _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT(S):

ADDITIONAL INFORMATION (unique physical descriptions, specific behaviors problems, triggers, issues with authority, and how to respond. List of disabilities, acute medical conditions and recommended treatment):

RECOMMENDED SOOTHING TECHNIQUES:

MEDICATIONS: _____

FORM COMPLETED BY: _____

LIVONIA PD STAFF WHO RECEIVED THIS FORM:_____

NOTE: Please update this form with the Livonia Police Department every two years