Ozaukee County Safety Registry

Instructions:

1. **Complete both sides of this form.**
2. **Attach a recent picture of the person being registered.**
3. **Send completed form to:**

Ozaukee County Aging and Disability Resource Center
121 W. Main St. Port Washington, WI 53074

Describe the person being registered:

Name (last, first, middle initial): _____

Name they respond to/nickname: _____

Address: _____

_____

Their cell phone number and carrier: _____

Sex: female male Date of birth: _____

Race:
__ Caucasian
__ African American
__ Native American
__ Hispanic
__ Asian

Eye color:
__ Hazel
__ Blue
__ Green
__ Brown

Hair color:
__ Brown __ Blonde
__ White __ Black
__ Gray __ Red
__ Bald

Weight: _____

Height: _____

Visible identifiable marks, scars, tattoos:

_____

_____

Medical conditions/medications that could be life threatening:

_____

_____

_____

_____

_____

Adaptive Aids (circle those which apply):
Glasses, hearing aids, walker, cane
Other: _____

Possible Destinations (places likely to go, etc.):

_____

Where do they consider home?_____

Automobile they could be driving — color/make/model/ license plate:

_____

Remember to attach a recent picture of the person being registered. Aging and Disability Resource Center staff can come to their home and take this photo as needed. Please call (262) 284-8120 to arrange.

Best approaches/familiar topics: _____
_____
_____

Things to avoid/PTSD triggers/upsetting topics: _____
_____
_____

If this person is found wandering, who should be contacted by the Sheriff or Police Department? You may give up to four contact persons.

1st Contact person's name:
_____
Address: _____
_____
Relation to registered person:
_____
Home phone: _____
Cell phone: _____
Work phone: _____

2nd Contact person's name:
_____
Address: _____
_____
Relation to registered person:
_____
Home phone: _____
Cell phone: _____
Work phone: _____

3rd Contact person's name:
_____
Address: _____
_____
Relation to registered person:
_____
Home phone: _____
Cell phone: _____
Work phone: _____

4th Contact person's name:
_____
Address: _____
_____
Relation to registered person:
_____
Home phone: _____
Cell phone: _____
Work phone: _____

*** Name of the person completing this form: _____

Physician Information

Physician name: _____

Clinic Name: _____

Address: _____

Phone: _____

The information given on this form is confidential. This information will be maintained by the Ozaukee County Aging and Disability Resource Center. It will be shared only with law enforcement, Aging and Disability Resource Center, and the Department of Human Services