

Caring Hands – A Roy City Police Public Safety Program

The Roy City Police Department has instituted a Caring Hands Public Safety Program. Our Police Department prides itself on being proactive and immersed in community assistance. The Caring Hands Public Safety Program will focus on receiving vital information about its participants, such as mental health diagnosis, medication needs, visual and communicative impairments, etc. that will better aid our medical and public safety personnel should the need arise.

We recognize our community is diverse, that is why we have designed our program to be inclusive, as we are committed to assisting community members regardless of diagnosis. Caring Hands is not only for neurodiverse participants; whether a physical or neurological impairment, no participant will be denied.

Roy City medical and public safety personnel recognize the inherent sensitivity that is necessary when caring for members of our community. Our desire is that our personnel will combine information from the Caring Hands Program, along with advanced training, to better engage and communicate effectively when responding to incidents.

Please take a moment to review our program participant form. This form can be filled out by a parent/guardian, foster family, legal representative, or legal guardian. This program is completely voluntary, and you can choose to no longer participate should your circumstances change. The Caring Hands Program shall remain strictly confidential, and the information listed will only be used to aid emergency medical and police responders.

When filling out the form, be sure to include any information you think is pertinent. There is no detail too insignificant. Be sure to submit an updated photo of the participant when you drop off the form to the Roy City Police Department. Our department will reach out to contact the person who has submitted the Caring Hands form, as an annual reminder to update the form for any applicable changes.

Together, please join us, as we look forward to watching this program grow.

Kindly,

Roy City Police Department and Roy City Corporation





Caring Hands – A Roy City Police Public Safety Program



Participant Information Form

This form requires a signature on the last page and may be filled out by the individual with the specific need, their parent/guardian, foster family, legal representative, or legal guardian. Submitting this form is voluntary, but please provide all the details that you can, using additional pages if necessary and attaching it to this form.

Participant's Information

Last Name: _____ First Name: _____ M.I.: _____

Nickname or Preferred Name: _____ Date of Birth: _____

Gender: Female Male Race: _____ Primary Language: _____

Home Address: _____ Zip: _____

Primary Phone: _____ Cell Phone: _____ Email: _____

Physical Description

Height: _____ Ft. _____ In. Weight: _____ Hair Color: _____ Eye Color: _____

Distinguishing marks, scars, tattoos, etc. Please describe and list locations _____

Does participant wear an ID bracelet or alert band? Yes No

If "Yes", type and location worn: _____

Employment and/or Educational Facilities

Does participant reside in a care facility? Yes No If "Yes" which facility: _____

Facility Address: _____ Zip: _____

Does participant attend school? Yes No If "Yes" which district is the school in: _____

School address: _____ Zip: _____

Grade: _____ Teacher's Name: _____

Does participant ride any of the following: School Bus Transit Bus Care Facility Bus/Van None

Special Needs/Impairments/Medical Conditions

Alzheimer's Autism Dementia Down Syndrome Epilepsy Hearing Impairment

Mobility Impairment Speech Impairment Visual Impairment Other: _____

Mental Health Diagnosis: _____

Other Medical Conditions not listed: _____

****The Roy City Fire Department strongly recommends individuals dependent on electrically powered medical equipment due to life-threatening medical conditions, consider providing themselves with some type of back-up power supply to limit the potential impact of electrical power outages.****

Does participant use any electrically powered medical equipment? Yes No

If “Yes” what type of equipment is used and for what purpose is it required:

Does participant require 24-hour use of the electrically powered medical equipment? Yes No

Does the electrically powered medical equipment have a battery backup? Yes No

Communication

Please rate participants ability to communicate and understand directions:

Communicate

Understand Directions

Verbally: None Poor Fair Good

Verbally: None Poor Fair Good

Written: None Poor Fair Good

Written: None Poor Fair Good

Does participant have any specific communication needs?

AAC/Electronic Communication Device

Other: _____

Medication(s)

List any medications participant is **currently** taking

_____	_____
Medication	Reason
_____	_____
Medication	Reason
_____	_____
Medication	Reason
_____	_____
Medication	Reason
_____	_____
Medication	Reason
_____	_____
Medication	Reason
_____	_____
Medication	Reason

Participants current Physician: _____ Phone Number: _____

Is there an up-to-date list of medications in the residence or on file with participants facility/school? Yes No

Vehicle(s) associated with Participant

- Year: _____ Make: _____ Model: _____ Color: _____
License Plate#: _____ State: _____
- Year: _____ Make: _____ Model: _____ Color: _____
License Plate#: _____ State: _____
- Year: _____ Make: _____ Model: _____ Color: _____
License Plate#: _____ State: _____

Additional Information

Does participant have a fear of authoritative individuals or strangers? Yes No

Is participant prone to wandering? Yes No

If “Yes” where are participants favorite wandering spots: _____

Is there a body of water close to participants residence or care facility/school? Yes No

If “Yes”, where is it located: _____

Favorite hiding places either in or around the home/care facility/school: _____

Triggers or actions by others to avoid, if possible, that could upset/disrupt the participant: _____

Calming strategies or positive reinforcements that could be utilized: _____

Any additional information you feel we should know: _____

Emergency Contact Information and/or Responsible Party

Primary Contact: _____ Relationship: _____
Home Address: _____ City/State/Zip: _____
Primary Phone: _____ Cell: _____ Work: _____
Email: _____

Secondary Contact: _____ Relationship: _____
Home Address: _____ City/State/Zip: _____
Primary Phone: _____ Cell: _____ Work: _____
Email: _____

Additional Contact: _____ Relationship: _____
Home Address: _____ City/State/Zip: _____
Primary Phone: _____ Cell: _____ Work: _____
Email: _____

Important – Please review the following before signing, and/or submitting this form.

If you choose to complete this form, information you have provided will be added to the Weber County Consolidated Dispatch System. The 911-Dispatchers can relay this information to Public Safety Personnel in advance. By initializing, you authorize the dissemination of the provided information above to Public Safety Personnel by 911 Dispatchers.

_____ **Initials Required**

Submitting this form is voluntary. This form requires a signature below and may be filled out by the individual with the specific disability/impairment, their parent/guardian, foster family, legal representative, or legal guardian. A signature is required to process the information contained on this form. It is the legal responsibility of the individual completing this form to update it immediately when changes occur, such as, but not limited to address, contact information, or physical appearance. **It is required that an update be done at a minimum of once annually, on the individuals birthday.**

_____ **Initials Required**

The information gathered as part of the Caring Hands program shall remain strictly confidential. The information shall be used only to aid emergency medical and police responders. No public safety worker shall knowingly violate this confidentiality clause. Except for willful or wanton misconduct, a public safety agency shall not be subject to civil liabilities for duties relating to the reporting of special needs individuals. Participation in this program will not result in preferential treatment.

_____ **Initials Required**

Name of person completing form: _____ Relationship: _____

Signature: _____ Date: _____

Photo submitted with this registration form? Yes No How many? _____

Additional pages included with this Participant Information Form? Yes No

Submit completed form to: **Roy City Police Department**
 Caring Hands – Records Division
 5051 South 1900 West
 Roy, UT 84067

