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Shelton Police Department
Systems & Information Manager
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Dear Shelton Resident

Thank you for your interest in the Shelton Police Department's Medical/Special Needs Registration Database. The purpose of the database is to be able to provide information quickly to emergency responders in the event of any emergency pertaining to persons or addresses registered in our database.

Please find the attached form that we ask you to fill out as part of your registration with the Shelton Police Department's Medical/Special Needs Registration Database. Information from the form will be entered in the Shelton Police Department Information Database Master Name file for the family member and as an address alert in our Computer Aided Dispatch (CAD) database.

Information entered into the Shelton Police Department's CAD database will trigger special information "alerts" when your address is entered into the CAD for a call for service. This alert will inform the dispatchers of a particular medical problem or emergency contact information for this residence. Additional information is added to our "Master Name" file that can assist emergency responders. Adding a photo to the registration forms can help emergency responders identify registered person who may not be able to communicate their name or address due to a medical problem. This photo can be added to the "Master Name" file as well.

Thank you for your participation in this program.

Shelton Police Department
Medical/Special Needs Database Registration

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Phone #:** _____

__ _____

Height: _____ **Weight:** _____ **Eye Color:** _____ **Hair Color:** _____

Distinguishing Characteristics (Scars/Marks/Tattoos):

Medical Conditions:

Medical Prosthetics/Devices

Cautions:

Primary Care Physician: _____ **Phone Number:** _____

Secondary Physician: _____ **Phone Number:** _____

Preferred Hospital: _____

Emergency Contact Person: _____ **Phone Number:** _____

Address: _____ **Relationship:** _____

_____

Emergency Contact Person: _____ **Phone Number:** _____

Address: _____ **Relationship:** _____

_____

I certify that I am the primary care provider for this person: I understand that this information is provided only to assist the Shelton Police Department in the event of emergency to assist this patient or to make contact with the above named emergency contact persons. I understand that I am required to update the Shelton Police Department in the event that any of the above information changes.

Send the completed form to: Shelton Police Department, Special Needs Database, 85 Wheeler Street, Shelton, CT 06484

_____ _____

Primary Care Provider Date:

rev 12/2020