

Ozaukee County Safety Registry

Instructions:

1. Complete both sides of this form.
2. Include a recent picture of the person being registered.
3. Mail or Email completed form to:
Ozaukee County Aging and Disability Resource Center
121 W. Main St. Port Washington, WI 53074
adrc@co.ozaukee.wi.us

Describe the person being registered:

Name (last, first, middle initial): _____

Name they respond to/nickname: _____

Address: _____

Their cell phone number **AND** carrier: _____

Sex: _____

Date of birth: _____

Race: _____

Eye color:

- ___ Hazel
- ___ Blue
- ___ Green
- ___ Brown

Hair color:

- ___ Brown
- ___ White
- ___ Gray
- ___ Bald
- ___ Blonde
- ___ Black
- ___ Red

Weight: _____

Height: _____

Visible identifiable marks, scars, tattoos:

List medical, physical, and/or cognitive impairments of concern (including conditions/medications that could be life threatening) :

Adaptive Aids: Glasses, hearing aids, walker, cane, other:

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

Where do they consider home? _____

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

Remember to provide 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: _____
Email: _____

2nd Contact person's name:

Address: _____

Relation to registered person:

Home phone: _____
Cell phone: _____
Work phone: _____
Email: _____

3rd Contact person's name:

Address: _____

Relation to registered person:

Home phone: _____
Cell phone: _____
Work phone: _____
Email: _____

4th Contact person's name:

Address: _____

Relation to registered person:

Home phone: _____
Cell phone: _____
Work phone: _____
Email _____

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

Physician Information

Physician name: _____
Clinic Name: _____
Address: _____
Phone: _____