OPS NATIONAL SPECIAL NEEDS REGISTRY

MANUAL REGISTRATION FORM

REGISTERING AGENCY:

_____

Registrant Information:

First Name: _____ Last Name: _____

Email: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Registrant Gender: _____ Registrant Height: _____ Registrant Weight: _____

Registrant Date of Birth (mm/dd/yyyy): _____/_____/_____ Phone Number: _____

Physical Description of Registrant (ex. The registrant is noticeably tall and skinny. He has long dark brown hair and is always clean shaved. He often wears a baseball cap.):

_____

_____

_____

Special Needs: (Check All that Apply):

☐ Alzheimers/Dementia ☐ Autism ☐ Diabetes / Hyperglycemic ☐ Dialysis ☐ Epilepsy

☐ Electricity Dependent ☐ Hearing Impairment / Deaf ☐ Hoarding Disorder

☐ I/DD - Intellectual / Developmental Disability ☐ Life Alert ☐ Mental Health Disorder

☐ Mobility Impairment: Crutches ☐ Mobility Impairment: Wheelchair

☐ Mobility Impairment: Other _____

☐ Obese ☐ Oxygen Dependent ☐ Project Life Saver ☐ PTSD (Post Traumatic Stress Disorder)

☐ Service Animal ☐ Sight Impairment / Blind ☐ Speech Impairment

☐ Other: _____

Describe any of the registrant's life-threatening medical concerns (i.e. food or medicine allergies, seizures, etc.):

_____

_____

_____

If the registrant uses an Epi-pen, please describe the location where it is stored:

_____

_____

Are there any triggers which affect the registrant? (i.e. loud noises, bright lights, etc.):

_____

_____

_____

Are there any calming methods used for the registrant? (describe):

_____

_____

_____

Does the registrant frequent / gravitate to any locations in particular? (i.e. water, playgrounds, etc.):

_____

_____

_____

Does the registrant wear corrective lenses? Circle One: Yes No

If yes, please provide Corrective Prescription Information / Description of Eyeglasses:

_____

_____

_____

Communication Methods: (Check All that Apply)

☐ Verbal ☐ Non-Verbal ☐ Sign Language ☐ Written

☐ Augmentative / Speech Assistance Device

Does the registrant own or frequently operate a motor vehicle? (Circle One): Yes No

If Yes please provide the license plate number: _____

Please add any additional information you may think will be helpful for first responders to know regarding the registrant:

_____

_____

_____

Primary Contact Information

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

Relationship to registrant (ex. Father): _____

Agency Use Only

Official Assisting with Registration: _____

Date: _____ **Location:** _____

Additional notes or information:

_____

_____

_____

Date Entered into the SNR: _____ **Entered By:** _____

Filing Instructions:

Once this form is complete, the registering agency's OPS SNR representative shall immediately manually enter the information into the SNR from any available OPS Community Interface exactly as written (making sure to select the appropriate agency on the interface). Do not in any way alter the information, add, or delete anything that is documented on this form. Once this information is added, the OPS SNR shall document the steps taken in the provided SNR notes section for this registration. This document should then be saved to an appropriate location for future reference.