



Clallam County Health and Human Services

PROJECT SAFER RESPONSE FORM

111. E 3rd Street, 1st Floor
Port Angeles, WA 98362
Phone: (360) 417-2377



Information disclosed will help in accomplishing the goals for “Project SAFER”. The information obtained in this document will be disclosed only to the extent necessary in aiding in the positive interactions with First Responders, or as required by law. **Medical information will be protected under HIPAA.**

This project is in collaboration between Clallam County Sheriff’s Office, Developmental Disabilities Administration, Clallam County Developmental Disabilities (Health and Human Services), along with other essential community members. Our goal is to ensure positive outcomes and interactions between all community members and First Responders.

Section 1: Individual ID

Recent Photograph				
<ol style="list-style-type: none"> 1. Attach a photo with this form or 2. Bring the individual into the Clallam County Health and Human Services Office and we will take the picture for you. <p><i>This photograph may be released if requested as a public record.</i></p>				
Legal Name:				
Nickname:	Sex:	Date of Birth:	Age:	Race:
Primary Disability (Not Required):				
Primary de-escalation suggestions (words to use; client interests; safe objects):				
Primary Contact:			Phone:	

Section 2: Individual Information

Weight:	Height:	Hair Color:	Eye Color:	Identifying Marks (birthmarks, scars, tattoos, piercings):
Cell Phone:			Home Phone:	
Home Address:				
City:		State:		Zip Code:
How long has the individual been living at this address?				
Washington Driver's License or State ID Number:				
Does the individual's disability make him/her at-risk for wandering? Yes or No				
If YES , please explain:				
Does the individual have any mobility impairments? Yes or No				
If YES , please explain:				
Please add additional information that may assist First Responders while interacting with the individual (attach a separate page if needed):				

Section 3: Family Member / Primary Caregiver Information

Full Name:		
Relationship to Individual:	What does the individual call you?	
Home Address:		
City:	State:	Zip Code:
Cell Phone:	Home Phone:	Work Phone:
Personal E-Mail:	Work E-Mail:	
Washington Driver's License or State ID Number:		
Other Relevant Information:		

Section 4: Family Member / Secondary Caregiver Information

Full Name:		
Relationship to Individual:	What does the individual call you?	
Home Address:		
City:	State:	Zip Code:
Cell Phone:	Home Phone:	Work Phone:
Personal E-Mail:	Work E-Mail:	
Washington Driver's License or State ID Number:		
Other Relevant Information:		

Section 5: Health & Psychological Conditions

Medical/Safety/Allergy Conditions:

Psychological Conditions:

Medication(s) and Dosage (please list):

Medication(s) Purpose:

Consequence of **NOT** taking this medication:

Please add any other relevant health and psychological information that may assist First Responders:

Section 6: Additional Family Friends Contacts

Name:		Relationship to Individual:
Home Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:
Name:		Relationship to Individual:
Home Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:
Name:		Relationship to Individual:
Home Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:

Section 7: Form Contact and Authorization of Release of Medical Information

Person filling out form:		Date:
Street Address:		
Cell Phone:	Home Phone:	E-Mail:
This is a revised form Yes or No		Date of Revision:

I hereby authorize Clallam County Health and Human Services – Public Health to share the above medical information with regional first responders only to the extent necessary to alert them to the special considerations/accommodations listed within.

Print Name

Signature

Date

If this form is being completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of Person completing this form

Signature of Person completing this form

Date