NEWPORT POLICE DEPARTMENT

59 Main Street
Newport, NH 03773
TEL. (603)863-3232 Fax.(603)863-1372

COGNITIVE CLASSIFICATION REGISTRATION FORM

Name:_____ DOB:_____

Race:_____ Heaight:_____ Weight:_____Eyes:_____ Hair:_____

Verbal or Non-Verbal:_____ Primary Language:_____

Scars, Marks, Tattoos, Prothesis:_____

_____

Does the Individual Attend Daycare? ☐ Yes ☐ No Where?_____

Individuals Physician Name:_____ Physician's Phone:_____

Medications:_____

Any additional physical problems?_____

Does the Individual Drive? ☐ Yes ☐ No Have access to a Vehicle? ☐ Yes ☐ No

If yes, Reg/Plate Number:_____ State:_____ Model:_____ Make:_____

Year:_____ Color:_____

Does the Individual carry identification? ☐ Yes ☐ No

Does the Individual have particular habits?_____

Is the individual physically aggressive? ☐ Yes ☐ No

Other Helpful Information:_____

Hobbies and/or favorite locations?_____

CAREGIVER INFORMATION

Individual lives with:_____ Relationship to Individual:_____

Address:_____ Phone:_____

Second Contact:_____Phone:_____

Address:_____

Third Contact:_____ Phone:_____

Address:_____

I, _____, give my permission for the Newport Police Department to retain this information, to be kept confidentially on file for the purposes of identification and assistance relative to COGNITIVE IMPAIRMENT.

Signature:_____ Date:_____

☐ I have included photos of the Individual ☐ I have included photos of Scars, Mark and Tattoos

Please return the completed form to Newport Police Department or email to Krowe@newportnh.gov