

This form is to assist first responders in more effectively responding to an emergency situation that a member of your household with a disability may experience. Please complete the following voluntary questionnaire and return it by emailing Sergeant Eric Keiper at ekeiper@kingstonpd.org, by mail to 500 Wyoming Avenue, Kingston, Pennsylvania 18704, or you may also drop it off. You may also return it to fguido@kingstonpafire.org. Completed forms may also be sent to Chief Frank Guido at fguido@kingstonpafire.org.

If you choose to respond, the information will be submitted into the Kingston Police and Fire's 911 CAD system for use by Luzerne County 911 dispatchers. The purpose is to ensure that 911 dispatchers and emergency response personnel are aware, in advance, of any information you feel they would need to know about people with disabilities in your household in the event of an emergency.

Responding to this questionnaire is purely voluntary. You may choose to respond on behalf of all of your household members or only certain household members. If you choose to respond to this questionnaire, please be sure to provide your signature on the last page. (Your signature gives us the permission we need to process this information - without it the information cannot be processed.) In addition, this information will be removed from our files periodically therefore this form must be submitted every two (2) years to ensure that our files are accurate.

Please notify the Kingston Police Department at 570-288-3674 if there is any change to the information you provide- such as a change of address, phone number, etc.

QUESTIONS:

Your answers to the following questions will assist police, fire or medical personnel when they are responding to an emergency or other call from your home, in identifying and/or assisting you, or a person in your household who has a disability.

HEAD OF HOUSEHOLD / PARENT/ CAREGIVER or AGENCY: (18 years of age or older)

NAME: _____ AGE _____ M F

NAME: _____ AGE _____ M F

ADDRESS: _____

TELEPHONE NUMBERS:

HOME: ()-____-_____ WORK: ()-____-_____

CELLPHONE: ()-____-_____

DISABILITY OR MEDICAL CONDITIONS

NAME: _____ M F

DATE OF BIRTH: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

EYE COLOR: _____ HAIR COLOR: _____

SCARS/ IDENTIFYING MARKS: _____

PLEASE COMPLETE THE FOLLOWING:

- Blind Low vision Deaf Hard of hearing Communication
- Mental retardation Mental illness Autism Physical disability
- Seizure Other:

Any prescription medication or emergency medical treatment needed:

Favorite attraction or locations where they may be found:

Atypical behaviors or characteristics that may attract attention:

Favorite toys, objects, or discussion topics:

Approach, calming or de-escalation techniques most likely to work:

Method of communication, if nonverbal, sign language, picture board, written words:

Identification information:

Sensory or dietary issues:

Please the space below to provide any additional information you feel that the Kingston Municipal Police Department, as well as Kingston Fire Department should be aware of in order to more effectively respond to an emergency situation in your household. Is there a keyholder to your property or someone to be notified in case of an emergency?

IMPORTANT: By signing this questionnaire, I acknowledge that the information provided above was done so voluntarily for the sole purpose of assisting the Police and Fire Departments, through their 911 system and emergency response personnel, to more effectively respond to a potential emergency in or near my household. I also understand that providing this information does not entitle me or anyone in my household to preferential treatment, nor will it result in a timelier response by emergency response personnel. It is simply an attempt to provide emergency response personnel with information, which may be helpful when providing service to residents or occupants of my home.

SIGNATURE:

Head(s) of household:

_____ DATE _____

_____ DATE _____