Autism Family Network

SafetyLNK Wander Flag

First Responder Information

Date:_____

Name: _____ _____ _____
(Last) (First) (M.I.)

Address: _____ _____ NE _____
(Street) (City) (ZIP)

DOB:_____Sex:____Race:____HGT:____WGT:____Eyes:____Hair:____
MM/DD/YYYY

Medical Conditions:_____

Scars/Identifying Marks/Behaviors:_____

Identification:_____

Attractions:_____

School Information:_____

Preferred Method of Communication:_____

Other Information:_____

TRACKING INFORMATION:_____

PRIMARY EMERGENCY CONTACT INFORMATION:

Name:_____

Address:_____

DOB:_____ Relationship:_____
(mm/dd/yyyy)

Cell:_____ Work:_____ Home:_____

Email Addr:_____

SafetyLNK Wander Flag

First Responder Information

ALTERNATE CONTACT INFORMATION:

Name:_____

Address:_____

DOB:_____ Relationship:_____
(mm/dd/yyyy)

Cell:_____ Work:_____ Home:_____

Email Addr:_____

I hereby authorize Autism Family Network (AFN) to disclose my child's protected health information to law enforcement, including, but not limited to: the Lincoln Police Department, Lancaster County Sheriff's Department, and/or the Nebraska State Patrol for purposes of participating in the AFN Location Project (Project). I further understand and grant permission for the information to be exchanged among the agencies and/or their employees as part of the Project and without liability. A photocopy, faxed copy, or electronically transmitted copy of this authorization will be considered as valid as the original.

_____

Name of Patient

_____

Printed Name of Parent or Guardian (Relationship)

_____ _____

Signature Parent/Guardian Date

_____ _____

Autism Family Network Representative Date

Autism Family Network