Warren County Sheriff's Office

Care Connect Program

Consent and Information Release Form

Parent/Guardian Information:

Full name: _____ Date: _____

Last *First* *M.I.*

Address: _____ Phone: _____

Street address *Apt/Unit #*

_____ Email: _____

City *State* *Zip Code*

Relationship to the Special Needs Individual: ----------

Alternate Emergency Contact:

Full name: _____ Date: _____

Last *First* *M.I.*

Address: _____ Phone: _____

Street address *Apt/Unit #*

_____ Email: _____

City *State* *Zip Code*

Special Needs Individual Information:

Full name: _____ Date: _____

Last *First* *M.I.*

Address: _____ Phone: _____

Street address *Apt/Unit #*

_____ Email: _____

City *State* *Zip Code*

Special Needs Diagnosis or Condition (Optional):

Other:

Preferred Communication Method:

Other:

May Have Difficulty: (check all that apply)

- ☐ Understanding commands
- ☐ Speaking
- ☐ Responding quickly
- ☐ Maintaining eye contact
- ☐ Processing multiple instructions
- ☐ Other:

Behavioral Considerations (May Exhibit):

Known Triggers:

Helpful Calming Techniques:

Medical Information (optional):

Relevant medical conditions: _____

Medications affecting emergency response: _____

Allergies: _____

Mobility concerns: _____

Service Animal: ☐ No ☐ Yes If "yes", please describe: _____

Photograph Authorization:

I authorize the Warren County Sheriff's Office to maintain a current photograph of the individual in the CAD system to assist responding personnel with identification.

Approximate year photo taken: _____

Additional Information for Responders: **(Please provide any information that may help emergency responders safely interact with the individual)**

Consent and Release

I understand that participation in the Care Connect Program is entirely voluntary.
I authorize the Warren County Sheriff's Office to store the information provided on this form, including any photograph submitted, in the agency's Computer-Aided Dispatch (CAD) system for the purpose of assisting emergency responders during calls for service.
I understand:

- The information will be accessible only to authorized public safety personnel for official purposes.
- Every effort will be made to protect the confidentiality of the information in accordance with applicable law and agency policy, but I understand the information will be relayed via police radio and computer aided dispatch programs.
- Participation does not guarantee any specific emergency response or outcome.
- I may request updates or removal of this information from the CAD system at any time by contacting the agency.
- It is my responsibility to notify the agency if the information provided changes.
- I authorize the use or disclosure of Protected Health Information for the purpose of assisting First Responders and emergency dispatch personnel in providing safe, effective, and appropriate emergency resources. I have the right to revoke this authorization. To do so I understand I must submit my revocation in writing to the Warren County Sheriff's Office. The revocation will prevent further disclosure of my health information by the WCSO from the date of receipt.

By signing below, I certify that the information provided is accurate to the best of my knowledge and that I have the legal authority to authorize its release.

_____ _____

Participant (if applicable) Parent/Guardian (if applicable)

Program Purpose

The purpose of this program is to assist First Responders and emergency dispatch personnel in providing safe, effective, and appropriate emergency responses to individuals with autism spectrum disorder, developmental disabilities, cognitive impairments, communication disorders, or other special needs.

Participation in this program is completely voluntary. The information provided will be entered into the agency's Computer-Aided Dispatch (CAD) system and may be viewed by authorized emergency personnel during calls for service. To opt out call 270-842-1633 for the dispatch center.