

# Rolling Meadows Police Department

STEVEN WILLIAMS  
Chief of Police

A Nationally Accredited Law Enforcement Agency

Date: \_\_\_\_\_

## MEDICAL ALERT INFORMATION FILE

A separate form should be completed for each individual member of the residence to whom conditions apply. This information is entered into a Computer Aided Dispatch (CAD) database and only applies to the address listed below.

Resident's Name \_\_\_\_\_

Address: \_\_\_\_\_ Apt/Unit # \_\_\_\_\_

Building / Complex Name \_\_\_\_\_

Home Phone \_\_\_\_\_ TDD  Yes  No \_\_\_\_\_

### *Emergency notifications*

*(Please include area code)*

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Pager \_\_\_\_\_

City \_\_\_\_\_ Cellular \_\_\_\_\_ Work \_\_\_\_\_

This person has a key to my home  Yes  No

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Pager \_\_\_\_\_

City \_\_\_\_\_ Cellular \_\_\_\_\_ Work \_\_\_\_\_

This person has a key to my home  Yes  No

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Pager \_\_\_\_\_

City \_\_\_\_\_ Cellular \_\_\_\_\_ Work \_\_\_\_\_

This person has a key to my home  Yes  No

**Please update this information when it changes**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Use a cane, wheelchair, walker                       | <input type="checkbox"/> Asthma            | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Blind/Difficulty Seeing                              | <input type="checkbox"/> Using Oxygen      | <input type="checkbox"/> Deaf/Hard of Hearing |
| <input type="checkbox"/> Psychiatric/Emotional Problems                       | <input type="checkbox"/> Diabetic          | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Heart Condition                                      | <input type="checkbox"/> Pets in Residence | <input type="checkbox"/> Difficulty Speaking  |
| <input type="checkbox"/> Allergic to medications (please list): (print) _____ |  |   |
| <input type="checkbox"/> Other: _____   |  |   |

I understand that my medical information is confidential and protected by physician-patient privilege. I waive the physician-patient privilege relating to the authorization for release of my confidential medical information. I understand that I may revoke this authorization any time after written notice to **Rolling Meadows Police Department 911 Center** except to the extent that prior action has been taken on the basis of this authorization. I further understand that this information may be disseminated over the police and/or fire radio system and that the general public utilizing the proper radio receiving equipment can hear these radio transmissions.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Do not write in shaded section

CAD Updated by: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

I:\Medical Alert Information File 03/02 bjh