

# ROLLING MEADOWS POLICE DEPARTMENT

DAVID J. SCANLAN  
Chief of Police

Dedicated to Excellence

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

## PREMISE ALERT PROGRAM

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. This application expires after two years from the date of the application unless updated by the resident. See the reverse of this form for a more detailed Privacy Policy.

**By submitting this form I understand that this does not guarantee an immediate contact by the police department due to the potential of manpower limitations.**

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

Do not write in shaded section

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