



# CITY OF GROTON POLICE DEPARTMENT CITIZENS AT RISK DATABASE (CARD) SYSTEM



**\*\*REGISTRATION INFORMATION WILL BE KEPT CONFIDENTIAL\*\***

Client's Name: \_\_\_\_\_  
 Client's Address: \_\_\_\_\_  
 Primary Caregiver: \_\_\_\_\_  
 Relationship to Client: \_\_\_\_\_  
 Caregiver Address: \_\_\_\_\_  
 Caregiver Home Phone: \_\_\_\_\_ Caregiver Cell Phone: \_\_\_\_\_

### Client Information

Date of Birth	Height	Weight		Race
Eye Color	Hair Color	Male	Female	
Complexion (circle one)	Fair	Medium	Dark	
<i>Circle the characteristics that apply:</i>				
Glasses	Contacts	Hearing Aid	Wig	Beard
Bald	Cane	Right-Handed	Left-Handed	Other

### Describe/Location

Mole \_\_\_\_\_ Tattoo \_\_\_\_\_ Scar \_\_\_\_\_  
 Birth Mark \_\_\_\_\_ Any Handicap \_\_\_\_\_

### Client's Habits

Does client attend a Day Service Program?                      Yes                      No  
 If yes, where? \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Does client wander?                      Yes                      No  
 If yes, in any particular direction/place? \_\_\_\_\_  
 \_\_\_\_\_  
 Behavior traits so we can interact positively \_\_\_\_\_  
 \_\_\_\_\_  
 Client's primary language \_\_\_\_\_



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Can client become physically aggressive?                      Yes                      No  
 Can client become physically aggressive?                      Yes                      No  
 Does client still drive?    Yes                      No

License Plate Number	Make	Model	Year
Does client carry identification?	Yes	No	What kind?

## Contact Information

**Primary contact/Caregiver:** called first if person is found

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone: Home:** \_\_\_\_\_ **Work:** \_\_\_\_\_

**Cell:** \_\_\_\_\_ **Other:** \_\_\_\_\_

**Relationship to client:** \_\_\_\_\_

**Additional Contacts:** can be called if primary contact is not available.

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone: Home:** \_\_\_\_\_ **Work:** \_\_\_\_\_

**Cell:** \_\_\_\_\_ **Other:** \_\_\_\_\_

**Relationship to client:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone: Home:** \_\_\_\_\_ **Work:** \_\_\_\_\_

**Cell:** \_\_\_\_\_ **Other:** \_\_\_\_\_

**Relationship to client:** \_\_\_\_\_



CITY OF GROTON  
POLICE DEPARTMENT  
CITIZENS AT RISK DATABASE  
(CARD) SYSTEM



**Emergency Medical Information**

Physician Name: \_\_\_\_\_

Physician Telephone Number: \_\_\_\_\_

Medical Concerns: \_\_\_\_\_

\_\_\_\_\_

Critical Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other helpful comments/information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE ALLOW FIVE (5) BUSINESS DAYS FOR YOUR INFORMATION TO BE UPLOADED INTO THE SYSTEM.**

*FOR STAFF USE ONLY:* Entry Date: \_\_\_\_\_ Initials: \_\_\_\_\_



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## Authorization

Contact Name: \_\_\_\_\_

I, \_\_\_\_\_, authorize the use of this information with the City of Groton Police Department and with other agencies where I receive services. I understand that this information will be filed and kept confidential to the extent of law and used only for purposes of identification and assistance related to the safe return efforts and relate first responder assistance activities. Authorization can be withdrawn at any time.

List of other agencies that provide me services:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Client Signature: \_\_\_\_\_

Authorized Representative Signature: \_\_\_\_\_

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

Please Check One:

- ( ) Power of Attorney (POA)
- ( ) Durable Power of Attorney Healthcare (DPAHC)
- ( ) Guardian
- ( ) Client