Ashland Police Department

12 Union Street
Ashland, Massachusetts 01721
Tel. (508) 881-1212 Fax. (508) 881-0105

COGNITIVE CLASSIFICATION REGISTRATION FORM

This is a cooperative effort of the Ashland Police Department and the Ashland Council on Aging to assist family members and/or caregivers of individuals with cognitive impairment.

Return completed form to:
ASHLAND POLICE DEPARTMENT
12 UNION STREET
ASHLAND, MA 01721
C/O OFFICER KASEY OESTREICHER

Or email: koestreicher@ashlandpd.org
Fax: 508-881-0105

Attach recent photo here.
Head and Shoulder if possible.

INFORMATION

Name: _____ D.O.B.: _____

Race: _____ Height: _____ Weight: _____Eyes: _____Hair: _____

Verbal or Non-Verbal: _____ Primary Language: _____

Identifying Marks: _____ Right-Handed: _____

Tattoos, scars, prosthesis: _____ Left-Handed: _____

Does the Individual Attend a Daycare? Yes: _____ No: _____

If yes where: _____

Individual's Physician Name: _____ Physician's Phone: _____

Medications: _____

Any additional physical problems? _____

_____

COGNITIVE CLASSIFICATION REGISTRATION FORM

Does the Individual Drive? Yes: _____ No: _____ Have Access to a Car? Yes: _____ No: _____

If yes, Reg/Plate Number: _____ State: _____ Model: _____ Make: _____
Year: _____ Color: _____

Does the individual carry identification? Yes: _____ No: _____ If yes, what? _____

Does the individual have any particular habits? _____

Is the individual physically aggressive? Yes: _____ No: _____

Other Helpful Information: _____

Hobbies and/or favorite locations: _____

If reported missing before, where have they been found? _____

**Last revised date ___/___/_____

CAREGIVER INFORMATION

Individual lives with: _____

Relationship to individual: _____ Phone: _____

Address: _____ City/Town: _____ State: _____

Contact 2. Name: _____ Phone: _____

Address: _____ City/Town: _____ State: _____

Contact 3. Name: _____ Phone: _____

Address: _____ City/Town: _____ State: ____

RELEASE FORM

I, _____, give my permission for the Ashland Police Department to retain this information, to be kept confidentially on file for the purposes of identification and assistance relative to COGNITIVE IMPAIRMENT.

Signature: _____ Date: _____