



HANNIBAL POLICE DEPARTMENT

ELDER WATCH PROGRAM



PARTICIPANT

LAST NAME:				FIRST NAME:			
DOB:		SSN:		HOME PHONE:			
ADDRESS:				CELL PHONE:			
RACE:	SEX:	HGT:	WGT:	HAIR COLOR:	EYES:		
SPECIAL NEEDS:							
VEHICLE MAKE:		VEHICLE MODEL:			VEHICLE YEAR:		
VEHICLE COLOR:		LICENSE NUMBER:			LICENSE STATE:		

MEDICAL INFORMATION

DOCTOR'S NAME:				PHONE:			
HOSPITAL:							
CHRONIC ILLNESSES:							
ALLERGIES:							
MEDICATION:							
DO YOU HAVE A LIVING WILL? YES NO (CIRCLE ONE)							
DO YOU HAVE AN OFFICIAL AND SIGNED DNR (DO NOT RESUSITATE) FORM AT HOME? YES NO (CIRCLE ONE)							
LOCATION OF LIVING WILL AND DNR FORM:							

DURABLE POWER OF ATTORNEY

NAME:				HOME /CELL PHONE:			
ADDRESS:							



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EMERGENCY INFORMATION		
NAME:		ADDRESS:
HOME PHONE:	WORK PHONE:	CELL PHONE:
DOES ANYONE HAVE A KEY TO YOUR HOME? YES NO (CIRCLE ONE)		
LIST THEIR INFORMATION BELOW:		
NAME:		ADDRESS:
HOME PHONE:	WORK PHONE:	CELL PHONE:
RELATIVE'S INFORMATION		
NAME:		RELATIONSHIP:
ADDRESS:		
HOME PHONE:	WORK PHONE:	CELL PHONE:
DO THEY HAVE A KEY TO YOUR HOME? YES NO (CIRCLE ONE)		
NAME:		RELATIONSHIP:
ADDRESS:		
HOME PHONE:	WORK PHONE:	CELL PHONE:
DO THEY HAVE A KEY TO YOUR HOME? YES NO (CIRCLE ONE)		
SOCIAL WORKER/AGENCY INFORMATION		
AGENCY NAME:		CASE WORKER:
PHONE NUMBER:	DOES AGENCY HAVE A KEY TO YOUR HOME? YES NO (CIRCLE ONE)	
FUNERAL HOME REQUEST:		

I am voluntarily participating in the ELDERWATCH program. I understand that this is a cooperative program involving the Hannibal Police Department. With your participation with this program, the City will be able to better meet your needs and the needs of the community. Your signature will allow us to share this information with other emergency agencies.

SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

PLEASE RETURN FORM TO: HANNIBAL POLICE DEPARTMENT, 777 BROADWAY, HANNIBAL, MO