



Project Lifesaver Application

Date: _____

Child's Last Name: _____ First Name: _____

Nickname: _____ Gender: M ___ F _____

D.O.B.: _____ Current Age: _____ WJCS Existing Client? _____

Address: _____ Primary Telephone #: _____

_____ Other Phone #: _____

Identification worn: (jewelry, medic alert, clothing tags, etc) _____

Physical Description:

Height: _____ Weight: _____ Hair color: _____

Eye color: _____ Hair style: _____ Build: _____

Complexion: Fair ___ Medium ___ Dark ___

Glasses? _____ Hearing Aids? _____ Contacts? _____

If yes, are they worn full time? _____

Distinguishing characteristics? (Birthmark, mole, scar, tattoo, etc.)

Medical information:

Is there a medical diagnosis? Yes ___ No ___ Explain: _____

Seizures? Yes ___ No ___

Current Medications:

MEDICATION NAME	DOSE	FREQUENCY

Medical / Psychological Care Providers:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Medication Allergies: _____

Behavioral Information:

Is He/She verbal? Yes: _____ Limited: _____ No: _____

Is the primary language English? Yes _____ No _____

If not, what language is spoken? _____

If non-verbal method of communication (sign language, picture board, written word, etc)

If verbal, can the person communicate his/her name, address, and phone #:

Yes _____ No _____

Does he/ she understand speech? Yes _____ No _____

Is the person sensitive to sensory input? If "Yes", please indicate:

Loud noises (i.e. sirens): _____ physical touch: _____ Bright lights: _____

If exposed to sensory input what behaviors might be anticipated _____

Special interests in any topic, object or theme? _____

Objects/articles usually carried by the person: _____

Does he/she self-stimulate? (i.e. flap arms, jitter, etc.) Yes _____ Sometimes _____ No _____

Explain: _____

Self-injurious behavior? Yes _____ Sometimes _____ No _____

Explain: _____

History of Aggression? Yes _____ Sometimes _____ No _____

Aggression toward others Yes _____ Sometimes _____ No _____

Explain: _____

Any fears, anxieties or triggers which upset him/her? If so what? _____

Wandering/ Elopement History:

Is there any prior history of the persons becoming lost, wandering or eloping?

Yes _____ No _____

If "Yes", please describe the event(s): _____

Location found: _____

By Whom: _____

Actions taken: _____

Favorite locations where the person may be found if missing or wandering? _____

Will the person talk to strangers? Yes _____ No _____

Is the person a danger to self or others? Yes _____ No _____

Explain: _____

Is there any additional information you would like to provide regarding the individual?

Parent/Guardian Contact Information:

Name: _____

Relationship to child: _____

Address (if different from child):

Home phone #: _____ Work phone #: _____

Cell Phone #: _____ Work Fax #: _____

Email(s): _____

Name of Employer: _____

Employer's Address: _____

Employer's Phone: _____

**If you have any questions or concerns please call Isabel M Pettersen (see below).
This completed application needs to be sent to:**

Isabel M Pettersen
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White Plains, NY 10603
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914-761-0600 x2230