Project Lifesaver Application

Date:_____ ***OPWDD eligible?*** _____

Child's Last Name: _____ First Name: _____

Nickname: _____ Gender: M ____ F_____

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

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?
_____
_____

Mother/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/Address: _____

_____

Employer's Phone: _____

Father Contact Information:

Name: _____

Address (if different): _____

Cell# _____ Work phone# _____

Email(s): _____

Name of Employer/address: _____

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

Isabel M Pettersen
WJCS – Program Manager
845 North Broadway
White Plains, NY 10603
Email: ipettersen@wjcs.com
914-761-0600 x2230

In addition to this application, we will need a recent **PHOTO** of the client to upload into his/her Project Lifesaver profile. The client's body should be clearly visible, dressed in regular indoor clothing, and the client should NOT be wearing a hat/cap/hoodie or any bulky clothing such as jackets/coats/gloves/boots. Make sure the client is facing the camera, and standing in front of a blank wall or the back of a door.
Make sure the photo is labeled with the client's name and that it is a JPEG or PNG.

Please send the photo as an attachment in an email to: ipettersen@wjcs.com .