

Forest View Police Department Autism Awareness Program

Parent(s) / Legal Guardian:		
Relationship to Special Assistance Family Member:		
Primary Address:		
City: St	ate:	_ Zip code:
Primary Contact Number(s):		
Secondary Contact number(s):		
Special Assistance Family Member:		
DOB:	Age:	
Medical Diagnosis: Any special medical needs:		
Special interaction instructions (hobbies, personal interests):		
Additional information or assistance requested:		
Parent/Guardian signature:		Date:
Parent/Guardian signature:		Date:
	AUTISM NOTICE	

AUTISM NOTICE
Person May Not
Respond
To Verbal Direction.
Thank you for your
KINDNESS, SUPPORT,
and PATIENCE!