Forest View Police Department
Autism Awareness Program

Parent(s) / Legal Guardian: _____

Relationship to Special Assistance Family Member: _____

Primary Address: _____

City: _____ State: _____ 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: