

ST. CHARLES POLICE AND FIRE DEPARTMENTS

ELDERWATCH PROGRAM

PARTICIPANT								
Last Name:			First Name:					
Date of Birth:			Home Phone:					
Address:			Cell Phone:					
Race:	Sex:	Hgt:	Wgt:	I	Hair Color:	Eyes:		
Special needs or Consideration:								
MEDICAL INFORMATION								
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 Resuscitate) request form at home?								
Yes No (Circle one)								
Location in home of Living Will and DNR request form:								
DURABLE POWER OF ATTORNEY								
Name: Home Ph								
			Cell Ph	one:				
Address:								



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EMERGENCY/NEIGHBOR/SOCIAL WORKER-AGENCY INFORMATION							
Name:		Address:					
Home phone:		Work phone:					
Cell phone:							
Does this contact have a key	to your home? Yes	No (Circle o	one)				
	RELATIVE'S	INFORMATION					
Name:		Relationship:					
Address:	City:		State:				
Home phone: Cell phone Work phone:		Key to house?					
			yes no				
Name:		Relationship:					
Address:	City:		State:				
Home phone:	Work phone:		Key to house?				
Cell phone:			yes no				
Funeral Home Request:	<u> </u>		!				
involving the ST. CHARLES the City will be able to better share this information with ot	S POLICE AND FIRE DE meet your needs and the her emergency agencies.	EPARTMENT. Wineeds of the comm	and that this is a cooperative program the your participation in this program unity. Your signature will allow us to the:				
Witness:		Da	ate:				
Please return this form to:	Elderly Services Officer St. Charles Police Depart 1515 W. Main St. St Charles, IL 60174	tment					

NOTE: THE KANE COUNTY SHERIFF'S DEPARTMENT DOES NOT PARTICIPATE IN THIS PROGRAM. THEY OFFER "PREMISE ALERT" TO ASSIST THOSE IN UNINCORPORATED AREAS.