

KANE COUNTY SHERIFF'S OFFICE

37W755 Rt. 38, Ste. A, St. Charles, IL 60175

Ph# (630) 232-6840 Fax# (630) 208-2047



Patrick B. Perez – Sheriff

Date: _____

PREMISE ALERT PROGRAM (PAP) INFORMATION FILE

A separate form should be completed for each individual member of the residence to whom conditions apply. This information is entered into a Computer Aided Dispatch (CAD) database and only applies to the address listed below.

Resident's Name: _____ Age: _____ Date of Birth: ____ / ____ / ____

Address: _____ Apt/Unit # _____

Building / Complex Name _____

Home Phone: _____ TDD Yes No

Emergency notifications

(Please include area code)

Name _____ Home Phone _____ Pager _____

City _____ Cellular _____ Work _____

This person has a key to my home Yes No

Name _____ Home Phone _____ Pager _____

City _____ Cellular _____ Work _____

This person has a key to my home Yes No

Name _____ Home Phone _____ Pager _____

City _____ Cellular _____ Work _____

This person has a key to my home Yes No

Please update this information when it changes

- | | | |
|---|--|---|
| <input type="checkbox"/> Use a cane, wheelchair, walker | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Blind/Difficulty Seeing | <input type="checkbox"/> Using Oxygen | <input type="checkbox"/> Deaf/Hard of Hearing |
| <input type="checkbox"/> Psychiatric/Emotional Problems | <input type="checkbox"/> Diabetic | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Pets in Residence | <input type="checkbox"/> Difficulty Speaking |
- Allergic to medications (please list): (print) _____
- Disabilities: _____
- Other: _____
- Other: _____
- Other: _____

Hazards

- Weapons (circle any that apply): Handguns - Rifles - Shotgun - Explosives - Other _____
- Other: _____
- Other: _____

File of Life Card Completed and Located:

Automatic Garage Door Opener Key Pad Entry Code: Knox box

I understand that my medical information is confidential and protected by physician-patient privilege. I waive the physician-patient privilege relating to the authorization for release of my confidential medical information. I understand that I may revoke this authorization any time after written notice to **Kane County Sheriff's Office** except to the extent that prior action has been taken on the basis of this authorization. I further understand that this information may be disseminated over the police and/or fire radio system and that the general public utilizing the proper radio receiving equipment can hear these radio transmissions. Every two years an updated PAP form must be submitted to the Kane County Sheriff's Office, c/o Training Division. See more detailed Privacy Policy on line at www.kanesheriff.com.

By submitting this form I understand that this does not guarantee an immediate contact by the Kane County Sheriff's Office due to the potential of manpower limitations.

Signature _____ Date _____

Print Name of person completing form: _____ Date _____

Do not write in shaded section (For Communications Personnel Only)

CAD Updated by: _____ Badge: _____ Date: ____ / ____ / ____ Time: _____