

Project Lifesaver®

Caregiver Instructions

Emergency Phone or Pager:

1. Check the transmitter everyday with the tester provided
 2. If a problem exists or the transmitter isn't indicating transmission (no pulsing or steady burning red light), notify us right away.
 3. Always remember to sign and date the tester sheet
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1. Check the transmitter everyday with the tester provided
 2. If a problem exists or the transmitter isn't indicating transmission (no pulsing or steady burning red light), notify us right away.
 3. Always remember to sign and date the tester sheet.
 4. If the client is missing notify **911 Emergency Services**
 - A. If at home, you may give your client number and contact information so we can call you back while responding.
 - B. If you are not at home, be sure to give the telephone number where we may reach you as well as your client number.
 5. While 911 Emergency Services is responding check obvious places around your home.

EMAIL ADDRESS: _____

The frequency set on this Project Lifesaver device is meant for Indian River County and may be available in some other surrounding cooperating counties and will not work in other counties unless previous arrangements have been made.

Caregivers Signature: _____

Project Lifesaver®

Program Contract

If applicant is accepted into the Project Lifesaver Program, the following terms shall apply as agreed to upon the signing of the Project Lifesaver contract:

I acknowledge that the information I have provided is true and accurate to the best of my knowledge. All information provided has been given voluntarily, and I consent to the collection, use and disclosure of such information for the purposes of Project Lifesaver. Furthermore, I hereby represent and warrant that I have full power and authority as the duly authorized representative of the Applicant named below, to register and act on his/her behalf. My Power of Attorney and/or Power of Personal Care is attached, if needed.

THEREFORE, IN CONSIDERATION of the mutual promises and obligations contained herein, the sufficiency of which is acknowledged, the parties agree as follows, each to their respective obligations:

1. I understand that when I enroll an Applicant in Project Lifesaver, that it does not replace the need for constant supervised care of the person. I am, and remain, primarily responsible for supervised care and take full responsibility of protecting this person from wandering. I also understand that I, or a family member, must be present in the home with the Applicant at all times.
2. I understand that Project Lifesaver equipment is designed to be an additional aid to help locate a missing person and that there is no warranty, representation or guarantee that a person will be found because they are wearing a Project Lifesaver bracelet. Project Lifesaver equipment is designed to provide law enforcement personnel with an additional technology in attempting to locate the Applicant. I also acknowledge that this is an experimental program for aiding in the search and rescue of persons suffering from diminished mental capacity or other disability.
3. In order for Project Lifesaver to work, I have a responsibility to obey the instructions of the Program, follow all training, and make sure that the person that I enroll is wearing the Project Lifesaver transmitter bracelet. If the bracelet has been removed or is defective; I will call Project Lifesaver immediately.
4. When I notice that the Applicant enrolled has wandered off, I must immediately call the emergency number supplied by Project Lifesaver and report the Applicant as a missing person. Project Lifesaver teams will respond to search. I understand and acknowledge that the Project Lifesaver device cannot predict or report that the Applicant has wandered off. It is used solely as an aid for emergency personnel when notified the Applicant is missing.
5. I understand that I will pay a \$50. deposit when the project lifesaver device is placed on the applicant.
6. I understand that while Project Lifesaver is an electronic tracking device that assists in locating persons who wear the bracelet device, there may be unforeseen times or circumstances when individuals cannot be located even while wearing the transmitter bracelet. I will not hold Project Lifesaver or any of its employees or volunteers, Provincial or city Law Enforcement or Fire and Rescue Agencies (collectively the "Releases") involved liable for failure to locate the person using the system, and hereby release all such Releases from any claim, cause of action, loss or damages arising from any inability or delay in locating the Applicant.

7. I understand that all information I have provided in this application may be shared among Local Law Enforcement, Fire and Rescue, and other necessary agencies in the community where I reside. Therefore, I understand that none of the information I have provided or will provide in the future can be considered confidential or protected or private when used for the purposes of the Project Lifesaver Program, [notwithstanding the provisions of the Personal Information Protection and Electronic Documents Act].
8. I specifically waive any rights to confidentiality to the Applicant's medical records by Project Lifesaver International or any of Project Lifesaver's member agencies which includes dissemination of such information. I confirm that I have the authority by which to waive such rights.
9. I understand that Project Lifesaver is a program administered by:
Alzheimer & Parkinson Assn. of IRC. I agree to release and hold each agency and all of their respective personnel, officers and volunteers harmless from any and all claims of liability and/or damage, and waive any and all rights to seek recourse for any losses or injury that may occur as a result of participation in the Project Lifesaver Program.
10. I understand that the transmitter and tester remain the property of Alzheimer & Parkinson Assn. of IRC and when no longer being used by the Applicant to whom it was assigned will be returned undamaged to Alzheimer & Parkinson so others in need can participate in the Program. I shall remain liable for any loss or damage to all such equipment and for the replacement cost of \$400.00 for equipment unless the equipment is returned to Alzheimer & Parkinson Assn. of IRC.
11. I understand that if I fail to use the tester device at least once per day and record the results on the supplied test result monthly inspection sheet, or if I fail to notify 911 immediately when I discover the Applicant missing, or if I fail to notify Alzheimer & Parkinson when I test the transmitter device and find no signal indication, or if the Applicant refuses to wear or removes the device 3 (three) times, then the Applicant may be involuntarily removed from the program. All property will then be returned to Alzheimer & Parkinson and I will return to the original security measures, which were in place prior to enrollment in Project Lifesaver, and without recourse to Project Lifesaver.

CAREGIVERS NAME (PRINTED)

CAREGIVERS SIGNATURE

DATE

(WITNESS)

APPLICANTS NAME

FOR PROJECT LIFESAVER

Alzheimer & Parkinson Assn. of Indian River County 772-563-0505
(AFFILIATE NAME)

Client Number: _____

Frequency: 216- _____

Project Lifesaver®

Client Profile

Personal Data Questionnaire

This form is designed for Custodial Care Givers to provide, in advance, certain information that will be useful to Search Teams, should the need arise. Providing the information in advance of the need will allow Search Management Personnel the necessary information to establish a more effective search response.

Resident: _____

Address: _____

City/State: _____ Zip: _____

Phone: _____

Date Transmitter Placed: _____

Facility/Organization: _____ Phone: _____

Address: _____

PL Servicer filling out this form: _____

PL Servicer that places transmitter on: _____

Resident's Personal Data

Birthday: _____ Sex: Male/Female Race: _____

Nickname(s): _____

Most recent address: _____

Most recent place of work: _____

Most recent occupation: _____

Name of Spouse: _____ Living/deceased (circle)

Family/Friend Information

Other persons the resident might contact (family, friends, etc.)

Name: _____ Phone: _____

Address: _____

Relationship to client: _____

Name: _____ Phone: _____

Address: _____

Relationship to client: _____

Responsible Party Paying for client: _____

Diagnosis: _____

Physical Description

Height _____ ft. _____ in. Weight _____ lbs. Build _____

Hair color _____ Hair Style _____ Eye Color _____

Complexion _____ Beard Yes/No Sideburns Yes/No

Mustache Yes/No Balding Yes/No False Teeth Yes/No

Shape of facial features: Round/Square/Oval/Other _____

Distinguishing marks, scars, tattoos, etc. Describe _____

General Appearance _____

If Resident does not understand English, what language is understood? _____

Spoken word only Yes/No or Written/Spoken

Does Resident wear glasses? Yes/No Contacts? Yes/No Sunglasses Yes/No.

If yes to any of the above what style: _____

If resident wears glasses or corrective eyewear what degree of vision does he/she have not using the eyewear? None/Poor/Fair (circle one)

Personal Data Questionnaire

Does Resident wear a hearing aid? _____ what style? _____

If yes, what type of hearing without Aid? None/Poor/Fair (circle one)

Health/Psychological Condition

Any known physical handicaps? _____

(Describe please)

Any known medical problems? _____

(Describe please)

Medications taken regularly? _____

List any medication using correct name of drug and dosage being taken: _____

Consequences of NOT taking medications? _____

Attending Physician _____ Phone No. _____

Any Psychological Problems? Yes/No Nature _____

If Alzheimer's disease has been diagnosed, Answer the following:

1. Does the Resident remain oriented to Time and Person? Yes/No
Explain _____
2. Does the Resident recognize familiar persons and faces? Yes/No
Explain _____
3. Can the Resident travel to familiar locations? Yes/No
Explain _____
4. Does the Resident have decreased knowledge of current events or tend to re-live events in his/her life? Yes/No
Explain _____
5. Does the Resident sometimes clothe himself/herself improperly? Yes/No
Example: Putting shoes on the wrong feet, adding underwear over clothing?
Explain if necessary _____
6. Does the Resident remember his/her own name and the names of spouse and or children? Yes/No
Explain _____
7. Are the Resident's sleep patterns frequently? Yes/No
Explain _____
8. Does the Resident suffer from frequent personality and emotional changes? Yes/No
Explain _____
9. Does the Resident suffer from delusions (See Imaginary Visitors, Talk to his/her own reflection in the mirror, Imagine that their spouse is an imposter, etc?) Yes/NO
Explain _____
10. How good is the Resident's communication ability? None/Poor/Fair/Good/Excellent
(circle one please)

Personal Articles Normally Carried by the Resident:

Tobacco Products: Yes/No Type _____ Brand _____

Candy/Gum: Yes/No Brand _____

Matches: Yes/No Lighter: Yes/No Type _____

Food Items: _____

Facial tissue or other pocket/purse items: _____

Approximate Amount of Cash on Hand? \$ _____

Where Normally Carried _____

Handbag, Purse or Wallet:

Description _____ Type _____ Color _____

Jewelry (Please describe) _____

Watch? _____ Type _____ Color _____ Description _____

Equipment

Cane/Walker or _____ Hunting/Fishing, Etc. _____ (circle one or describe)

Other: _____

Experience

Familiar with area? Yes/No How recently _____ Days/Months/Years

If not local, what other areas are known to Resident? _____

Taken outdoor classes? Yes/No Where? _____ When? _____

Taken first-aid training? Yes/No Where? _____ When? _____

Involved in Scouting? Yes/No Explain _____

Military Experience? Yes/No Where? _____ When? _____

Recreational Outdoor Experience? Yes/No _____

Overnight Camping Experience? Yes/No _____

Ever been lost before? Yes/No Where _____

When _____ Time of Day _____

Located by searchers or walk out by himself/herself? _____

Location found _____

Actions taken _____

Ever go out alone? Yes/No stay on trails? Yes/NO

General Athletic Interest/Abilities _____

Personality Habits

Smoke? Yes/No How often _____ what _____ Brand _____

Drink Alcohol? Yes/No What Type? _____ Brand _____

Use Illicit Drugs? Yes/No How often _____ Type _____

Hobbies/Interests _____

Outgoing or Quiet; Likes Groups or being alone? _____

Evidence of Leadership Yes/No Explain _____

Ever been in trouble with the law? Yes/NO What _____

Religious? Yes/No what faith _____

What does Resident value most? _____

Which family member is resident closest to? _____ Relationship _____

Where was Resident born and raised? _____

Has Resident received any letter recently? Yes/No from Whom _____

Is resident afraid of Dogs? Yes/No The dark? Yes/No Noises? Yes/NO (circle one beside each)

Horses? Yes/No People? Yes/No Other (explain) _____ What

actions taken hurt? (Cry, shout, etc.?) _____

Will Resident talk to strangers? Yes/No(circle one).

Is the Resident DANGEROUS to him/herself or others? Yes/No(circle one)

ALZHEIMER

PARKINSON ASSOCIATION OF INDIAN RIVER COUNTY

Alzheimer & Parkinson Association of IRC (APAIRC)

PHOTO RELEASE FORM

I hereby grant the APAIRC permission to use my likeness in a photograph, video, or other digital media ("photo") in any and all of its publications, including web-based publications, without payment or other consideration.

I understand and agree that all photos will become the property of the APAIRC and will not be returned.

I hereby irrevocably authorize the APAIRC to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo.

I hereby hold harmless, release, and forever discharge the APAIRC from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I HAVE READ AND UNDERSTAND THE ABOVE PHOTO RELEASE. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENTS/GUARDIANS AS EVIDENCED BY THEIR SIGNATURES BELOW. I ACCEPT:

On behalf of (print name) _____

Signer /Relationship (print name) _____

Signature _____ Date _____

- PROJECT LIFESAVER®
- LOST SUBJECT PROFILE

• INCD. NAME	DATE	TIME	INCD. CMDR.
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• PERSONAL

• NAME	NICKNAME	AGE	RACE	SEX
• HOME ADDRESS		CITY	STATE	
• NAMES OF FAMILY OR				
• NEAREST RELATIVES				

• PHYSICAL DESCRIPTION

• HEIGHT	WEIGHT	COMPLEXION	HAIR COLOR
• HAIR STYLE	FACIAL HAIR	EYE COLOR	
• DISTINGUISHING MARKS			

• CLOTHING

• SHIRT	<input type="checkbox"/> STYLE & COLOR	•	• NOTES
• DRESS	<input type="checkbox"/> STYLE & COLOR	•	• NOTES
• SWEATER	<input type="checkbox"/> STYLE & COLOR	•	• NOTES
• PANTS	<input type="checkbox"/> STYLE & COLOR	•	• NOTES
• COAT	<input type="checkbox"/> STYLE & COLOR	•	• NOTES
• HAT	<input type="checkbox"/> STYLE & COLOR	•	• NOTES
• SHOES	<input type="checkbox"/> STYLE & COLOR	•	• NOTES
• SHOES SIZE	SOLE STYLE	TREAD PATTERN	

• PERSONAL ITEMS IN POSSESSION

•	
• WALLET/PURSE	<input type="checkbox"/>
• JEWELRY	<input type="checkbox"/>
• TOBACCO	<input type="checkbox"/>
• CANDY/GUM	<input type="checkbox"/>
• EYE GLASSES	<input type="checkbox"/>
• KNIFE/TOOLS	<input type="checkbox"/>
• CANE STICK	<input type="checkbox"/>
• OTHER	<input type="checkbox"/>

• PHYSICAL/MENTAL CONDITION

• PHYSICAL	•
• MENTAL	•
• MEDICATION	• <input type="checkbox"/>
• ALCOHOL	• <input type="checkbox"/>
• ILLICIT DRUGS	• <input type="checkbox"/>
• NOTES	

ADDITIONAL NOTES OR PICTURE

Additional Information:

Sheet _____ Frequency _____ Client # _____ ID Code _____

Project Lifesaver International Client Check Sheet

_____ Client Name _____ Client City/Zip _____ Client Location (Address) _____ Contact Phone _____
 _____ Caregiver Contact _____ Caregiver Phone _____ Caregiver Relationship _____

☐ Client Facility ☐ House ☐ Apt. ☐ Duplex ☐ Trailer ☐ Hospital ☐ Nursing Home ☐ Asst. Living ☐ Secured ☐ Fenced

Day	Month	Time	Person Inspecting Equipment	Comments
1				
2				
3				
4				
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31				

	Transmitter	Battery	Case	"O" Ring	Band	Tester	Sheet
Install/New	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Replace/Modify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inspect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remove	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Visit1) _____
 _____ Caregiver Signature _____ Date _____ Responder Signature _____ Date _____

Visit2) _____
 _____ Caregiver Signature _____ Date _____ Responder Signature _____ Date _____

Sheet _____

Frequency _____

Client # _____

ID Code _____

Project Lifesaver International

Client Check Sheet

Client Name	Client City/Zip	Client Location (Address)	Contact Phone
Caregiver Contact	Caregiver Phone	Caregiver Relationship	

☐ Client Facility
 ☐ House
 ☐ Apt.
 ☐ Duplex
 ☐ Trailer
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	Transmitter	Battery	Case	"O" Ring	Band	Tester	Sheet
Install/New	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Replace/Modify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inspect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remove	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Visit1) _____
 Caregiver Signature Date

Responder Signature Date

Visit2) _____
 Caregiver Signature Date

Responder Signature Date