



Autism Safety Alert Form



Name: _____
D.O.B: _____ Age: _____ Sex: _____ Nickname: _____
Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____
Address: _____

Scars/Identifying Marks: _____

For all below Please Circle:

Communication:

- verbal
- non-verbal
- ASL
- pictures
- can write
- can read
- will repeat questions
- can answer yes/no questions
- scripting

Sensitive To:

- noise
- touch
- light
- crowds
- other: _____

Avoidance/Dislikes:

- eye contact
- being wet
- being dirty
- strangers
- clothes/shoes
- other: _____

Atypical Behaviors:

- speaks loudly
- self injury
- will run if chased
- vocal stimming
- high pitched noise
- little/no sense of danger
- sensory seeking
- other: _____

Medical:

- hearing impaired
- vision impaired
- seizures
- tics
- high pain tolerance
- other: _____

**Calming
Methods:**

- calm/quiet voice
- noise cancelling headphones
- time alone
- food/candy
- ask why upset
- other: _____

Emergency Contact Name & Phone Number:

Please submit with recent photograph