

S.K.C. EMERGENCY NUMBERS



Police Department



Fire Department



Doctor



Ambulance (EMT)



Hospital



Home



School/Daycare



Call 911



Visit our website:
www.safekidclub.com



Safe Kid Club®

Since 1985

NAME

A.K.A. / NICKNAME

AGE

COLOR OF EYES

COLOR OF HAIR

HEIGHT

WEIGHT

NATIONALITY

COMPLEXION

VISIBLE SCARS / MARKS

MEDICAL INFORMATION

PARENTS' / GUARDIANS' NAME *(Print)*

PARENTS' / GUARDIANS' PHONE #

CHILD CREATE A SAFETY PASSWORD

BEST FRIENDS' PHONE #

EMERGENCY PHONE #

COLOR OF CLOTHING

LAST SEEN LOCATION / TIME

LOCAL POLICE PHONE #

85 SINCE 1985®
SAFE KID CLUB

*Head & Shoulder
Professional Picture*

4x6

Black & White

or

Color Photo

SKC85 4B

Safe Kid Club®

*Sponsored by
Church, School, or Area Organizations*



No. _____

Date Completed _____

NAME _____
 A.K.A. / NICKNAME _____
 AGE _____
 COLOR OF EYES _____
 COLOR OF HAIR _____
 HEIGHT _____
 WEIGHT _____
 NATIONALITY _____
 COMPLEXION _____
 VISIBLE SCARS / MARKS _____
 MEDICAL INFORMATION _____
 PARENTS' / GUARDIANS' NAME *(Print)* _____
 PARENTS' / GUARDIANS' PHONE # _____
 EMERGENCY PHONE # _____
 COLOR OF CLOTHING (DESCRIBE) _____
 LAST SEEN LOCATION / TIME _____
 LOCAL POLICE PHONE # _____



*Head & Shoulder
 Professional Picture
 4x6
 Black & White
 or
 Color Photo*

*SKC85 4B
 Safe Kid Club ®*

1. R. THUMB	2. R. INDEX	3. R. MIDDLE	4. R. RING	5. R. LITTLE
6. L. THUMB	7. L. INDEX	8. L. MIDDLE	9. L. RING	10. L. LITTLE

LEFT FOUR FINGERS TAKEN SIMULTANEOUSLY L. THUMB R. THUMB RIGHT FOUR FINGERS TAKEN SIMULTANEOUSLY

FINGERPRINTS (By Local Police Department)

MEDICAL HISTORY

Present Medical History _____
 Past Medical History _____
 Allergies _____
 Current Medication _____
 Past Medication _____
 Blood Type _____
 Physician's Name _____ Physician's Phone: _____
 Hospital _____ Hospital Phone: _____
 Name of Medical Insurance _____ Policy #: _____
 Dentist's Name _____ Dentist's Phone: _____
 Name of Dental Insurance _____ Policy #: _____
 Present Medications: _____

 Past Medications: _____

MEDICAL AUTHORIZATION

I, the undersigned parent/legal guardian of _____, a minor, do hereby authorize any emergency personnel to use their judgement in obtaining medical treatment for my child. I give permission to the medical, dental or emergency room staff selected to render any emergency medical, surgical or dental treatment necessary. I understand that any costs incurred for my child for such emergency treatment will be my sole responsibility. It is also understood that effort will be made to contact the undersigned prior to rendering treatment to the child, but that none of the above treatment will be withheld if the undersigned cannot be reached.

Print Name _____ Signature _____ Date _____
Parent/Guardian Parent/Guardian

Print Name _____ Signature _____ Date _____
Witness Witness

ADDITIONAL CONTACT PERSON

Name _____ Relationship _____
 Street Address _____ Phone _____
 City _____ State _____ Zip _____