S.K.C. Emergency Numbers

Police Department

Fire Department

Doctor

Ambulance (EMT)

Hospital

Home

School/Daycare

85 SINCE 1985 ® SAFE KID CLUB

☎ **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

SKCEM 4G Safe Kid Club ®

Sponsored by Church, School, or Area Organizations

No.

Date Completed

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

EXTENDED MEDICAL HISTORY

☐ Medical ☐ Prescriptions ☐ Allergies ☐ Food Allergies ☐ Impairments

REPORT ALL FORMS OF ABUSE - PHYSICAL, MENTAL AND SEXUAL
STOP THE SHAME & THE PAIN

ALL ENTRIES REQUIRE NAME AND DATE.

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☐ Check here if additional history is included.