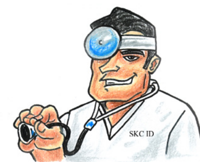
S.K.C. Emergency Numbers

Police Department

Fire Department



Doctor

Ambulance (EMT)

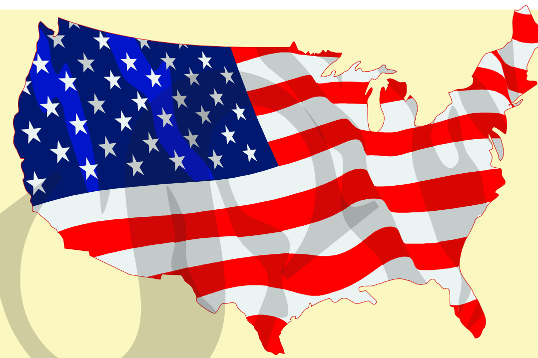
Hospital

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 #

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*

SAMPLE
SAMPLE

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

SAMPLE
SAMPLE