

S.K.C. EMERGENCY NUMBERS



Police Department



Fire Department



Doctor



Ambulance (EMT)



Hospital



Home



School/Daycare



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 _____



Call 911



Visit our website:
www.safekidclub.com

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

Lined area for extended medical history.

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

ALL ENTRIES REQUIRE NAME AND DATE.

A Product Of: www.safekidclub.com®

Check here if additional history is included.