

## Child Identification

Date This Is Completed: \_\_\_\_\_

Child's Birth Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Nickname: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

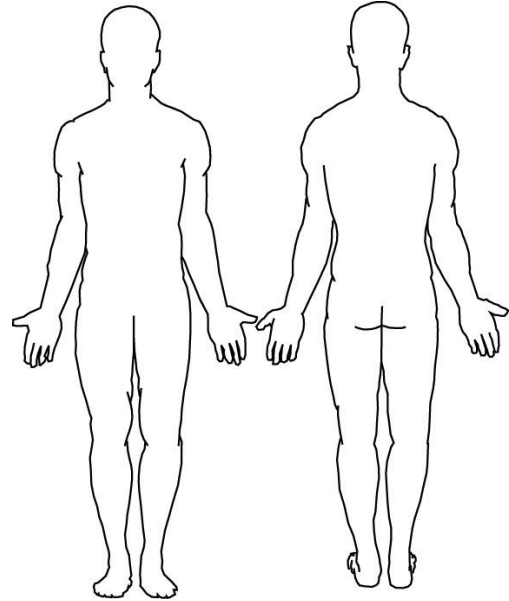
Chronic Allergies/Illnesses: \_\_\_\_\_

\_\_\_\_\_

My child wears:

☐ glasses ☐ contact lenses ☐ braces on teeth

Others: \_\_\_\_\_



Identifying marks (Birthmarks, scars, etc.)

Features and Characteristics: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Photo	Fingerprints				
	Left Pinkie	Left Ring	Left Middle	Left Index	Left Thumb
	<div style="height: 150px; width: 100%;"></div>				
Right Thumb		Right Index	Right Middle	Right Ring	Right Pinkie
<div style="height: 150px; width: 100%;"></div>					

Date of Picture: \_\_\_\_\_