

LEFT LITTLE

LEFT RING

LEFT MIDDLE

LEFT INDEX

LEFT THUMB

Child's Fingerprints Left Hand

# OPERATION SAFE CHILD ID SHEET

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

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

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

Child's Nickname: \_\_\_\_\_

Child's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Child's Phone Number: \_\_\_\_\_

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

Child's Height: \_\_\_\_\_ Child's Weight: \_\_\_\_\_

Child's Gender: \_\_\_\_\_ Child's Race: \_\_\_\_\_

Child's Eye Color: \_\_\_\_\_ Child's Hair Color: \_\_\_\_\_

Child's Blood Type: \_\_\_\_\_

Indicate Child's Scars, Birthmarks moles and their locations on child:

Front: \_\_\_\_\_

\_\_\_\_\_

Back: \_\_\_\_\_

\_\_\_\_\_

Child wears glasses [ ] Yes [ ] No Contacts [ ] Yes [ ] No

Child wears Braces [ ] Yes [ ] No

Child has pierced ears [ ] Yes [ ] No

Other: \_\_\_\_\_

\_\_\_\_\_

**Glue Child's Photo Here**  
(Update every 6 months)

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

Office Phone: \_\_\_\_\_

Emergency Number: \_\_\_\_\_

Child's Known Allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Medical Concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Attach two or three strands of hair including root.  
Do not tape over root.

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