

**PERSONAL INFORMATION**

**ONLY FOR YOUR RECORDS**

Name \_\_\_\_\_ Sex \_\_\_\_\_  
 Nickname \_\_\_\_\_ Blood Type \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Place of Birth \_\_\_\_\_  
 (Hospital/Other)  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Attending Physician \_\_\_\_\_

**Physical Features:**

Color of eyes \_\_\_\_\_ Wear glasses? \_\_\_\_\_ Contacts? \_\_\_\_\_  
 Color of hair \_\_\_\_\_ May change to \_\_\_\_\_

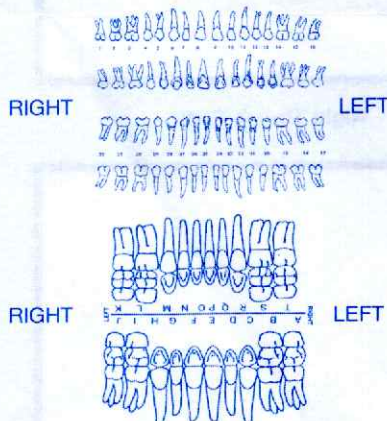
**Please Circle One From Each Category:**

<b>Body Type</b>	Slight build	Medium build	Heavy build
<b>Personality</b>	Outgoing	Average	Shy
<b>Sociability</b>	Very Independent	Average	Very Dependent
<b>Character</b>	Loud	Medium	Soft Spoken

Hand Preference \_\_\_\_\_ Able to swim? \_\_\_\_\_ Bicycle description \_\_\_\_\_  
 Language spoken or understood \_\_\_\_\_ Any physical handicap? \_\_\_\_\_  
 Has child ever run away for more than 24 hours? \_\_\_\_\_ School, Relative, Playmates \_\_\_\_\_  
 Any additional information (unusual habits, speech defects, etc.) \_\_\_\_\_  
 child's Signature (Printed) \_\_\_\_\_ Child's Signature (Cursive) \_\_\_\_\_

**DENTAL IDENTIFICATION CHART**

Note to Parent - Take your child's personal Child Safety Record with you each time that he or she visits the dentist for a check-up. Request your dentist to printout - digital x-rays on the charts provided in their record, attach to this form.



Dentist's name \_\_\_\_\_ Date \_\_\_\_\_  
 Dentist's name \_\_\_\_\_ Date \_\_\_\_\_

**PHYSICAL DESCRIPTION**

Please use the figure and numbered spaces to record the location and type of any distinguishing birthmarks, moles, scars, previously broken bones and prosthetics.

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

