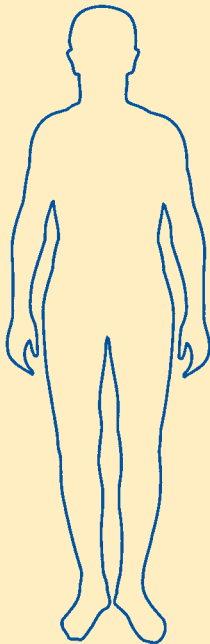


## Physical Information

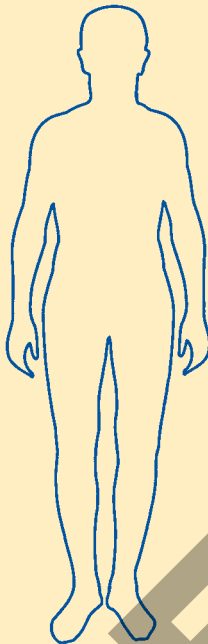
RACE _____		WEIGHT _____	
HAIR COLOR _____		EYE COLOR _____	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
GLASSES		BRACES	

## BODY CHART

Mark on the front and back of the figures and in the spaces below any identifying marks (birthmarks, scars, moles, broken bones, prosthetics, etc.).



front



back

## Instructions

1. Print your child's name and the date completed on the front cover. *(Update annually due to changes in your child's growth and physical characteristics.)*
2. Attach a recent photograph of your child in the space provided.
3. Enter in all information in the spaces provided.
4. Attach strands of your child's hair as a DNA sample.
5. Have the dental chart completed by your child's dentist.
6. Using the enclosed ink strip, fingerprint your child.
7. Keep this Identity Card stored in a safe, accessible place.
8. Make sure your child knows his or her complete name, address and telephone number including the area code.

# Child Identity Card

**SKILL  
BUILDER®**



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To reorder, call 877-329-0578  
and ask for product #PBCP42.

ISBN 1-56230-726-6

Child's Full Name

Date completed \_\_\_\_\_

## Child's Photograph

DATE PHOTOGRAPH TAKEN \_\_\_\_\_



Attach your child's  
most recent  
photograph  
here.

## Personal Information

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_



MALE



FEMALE

SOCIAL SECURITY # \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME TELEPHONE # \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

NEAREST OTHER RELATIVE \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

CHILD'S NICKNAMES \_\_\_\_\_

CHILD'S FRIENDS \_\_\_\_\_

## Medical Information

BLOOD TYPE \_\_\_\_\_

MEDICATIONS \_\_\_\_\_

CHRONIC ILLNESSES \_\_\_\_\_

ALLERGIES \_\_\_\_\_

DOCTOR'S NAME \_\_\_\_\_ TELEPHONE # \_\_\_\_\_



## DNA SAMPLE

Attach several strands of hair with roots and bulbs intact.

## DENTAL RECORD

Dental information to be completed by child's dentist.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
RIGHT								LEFT							
A B C D E								F G H I J							
T S R Q P								O N M L K							
32 31 30 29 28 27 26 25								24 23 22 21 20 19 18 17							

DENTIST'S NAME \_\_\_\_\_ TELEPHONE # \_\_\_\_\_



## FINGERPRINTS

Separate the two sides of the ink strip and place one half near the edge of a table. Roll each finger and thumb individually across the ink strip. Carefully roll each inked finger or thumb in its designated space on the card. Prints should include the first knuckle and be free of smudges.

RIGHT LITTLE		LEFT LITTLE
RIGHT RING		LEFT RING
RIGHT MIDDLE		LEFT MIDDLE
RIGHT INDEX		LEFT INDEX
RIGHT THUMB		LEFT THUMB