



## Child Identification Program - Information Collection Sheet

Providing any of the below information is voluntary, however the more information you provide, the better this resource will work for you if it is needed. Remember—the Masonic Children’s Foundation retains none of this information

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Last Name: \_\_\_\_\_  
Nickname: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ (MMDDYYYY, e.g. 04162008)  
Place of Birth: \_\_\_\_\_ (e.g. Independence, MO)  
Home Street Address: \_\_\_\_\_  
Street Address 2<sup>nd</sup>: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Home Phone Number: \_\_\_\_\_  
Child’s Phone Number: \_\_\_\_\_

### CHECK ONE IN EACH CATEGORY:

Gender:        Male            Female

**Predominate Race:**    Asian    Bla    African-Amer        Hispanic        Native American        Caucasian/White

Eye Color:            Black            Blue            Brown            Green            Gray            Hazel  
                          Maroon            Pink            Multicolored        Unknown

**Hair Color:**        Bald            Black            Blue            Brown            Blonde/Strawberry  
                          Green            Orange            Purple            Pink            Red/Auburn        Unknown

Height            \_\_\_\_\_ feet        \_\_\_\_\_ inches

Weight:            \_\_\_\_\_ pounds

Distinguishing Marks: \_\_\_\_\_  
(e.g. scars, moles, birthmarks, etc)

### PARENT INFORMATION:

If you would like both mother & father's name to appear on printout, put both names on Primary Parent Line (Jack & Jill Uphill)

### Primary Parent/Legal Guardian

Name: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent Phone #: ( ) \_\_\_\_\_

Parent Cell Phone #: ( ) \_\_\_\_\_

Parent Work Phone #:( ) \_\_\_\_\_

**Other Parent/Legal Guardian**

Name: \_\_\_\_\_

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

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

Parent Phone #: ( ) \_\_\_\_\_

Parent Cell Phone #: ( ) \_\_\_\_\_

Parent Work Phone #:( ) \_\_\_\_\_

**Additional Child Information**

Child's Doctor: \_\_\_\_\_

Doctor Phone #: ( ) \_\_\_\_\_

Doctor City & State: \_\_\_\_\_

Medical Needs:                      Yes                      No      *Please Choose one.*

Specific Medical Needs: \_\_\_\_\_  
(e.g. wheelchair, inhaler, etc.)

Medical Conditions: \_\_\_\_\_  
(e.g. cerebral palsy, asthma, etc.)

Medical Details: \_\_\_\_\_  
(e.g. medicines, etc.)

Child's Dentist: \_\_\_\_\_

Dentist Phone #: ( ) \_\_\_\_\_

Dentist City | State: ( ) \_\_\_\_\_

Known Clubs & Associations: \_\_\_\_\_  
(e.g. Cub Scouts, soccer, etc)

**Emergency Contact** *We recommend using someone other than a parent–grandparent, aunt, uncle, friend, etc.*

Emergency Name: \_\_\_\_\_

Emergency Phone #: ( ) \_\_\_\_\_

Disclaimer: This form has either been downloaded from the MoCHIP Web site (mochip.org) or distributed by a Masonic Lodge. The Missouri Masonic Children's Foundation is not responsible for the privately collected information assembled on this form. Please take extreme care to secure this sensitive information both prior to and after the MoCHIP event.