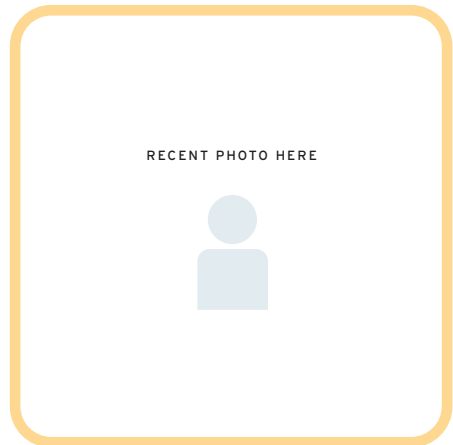


MEDICAL INFORMATION & PHOTOGRAPH



DATE OF PHOTOGRAPH ____ / ____ / ____

MEDICAL INFORMATION

PLACE OF BIRTH	BLOOD TYPE
MEDICATIONS	CHRONIC ILLNESS
ALLERGIES	
DOCTOR'S NAME	TELEPHONE

PERSONAL INFORMATION



PERSONAL INFORMATION

SOCIAL SECURITY NUMBER		DATE OF BIRTH
AGE	MALE	FEMALE
STREET ADDRESS		
CITY	STATE	ZIP
MOTHER'S NAME		TELEPHONE
FATHER'S NAME		TELEPHONE
NEAREST RELATIVE		TELEPHONE
CHILD'S FRIENDS		

FINGERPRINTS

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