

Date: _____



Pediatric Patient Identification and Tracking Form

Purpose: To assist in identifying, tracking and reunifying pediatric patients during a disaster

Note: All information within this form is **confidential** and should not be shared except with those assisting in the care of the patient. Developed by the Illinois Emergency Medical Services for Children.

Contact Information					
Tracking Number:		Date of Arrival:		Time of Arrival:	
Minor's Name (Last, First, Middle):				DOB:	
Address:				Age: _____ Mo / Yrs Check if Estimated ☐ Circle One	
Minor's Cell Phone:					
Parent/Guardian Name(s):					
Parent/Guardian Phone Number(s):					
Description					
Eye Color ☐ Brown ☐ Blue ☐ Green ☐ Gray	Hair Color ☐ Brown ☐ Blond ☐ Black ☐ Red ☐ Other:	Race ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Caucasian/White ☐ Hawaiian Native & Pacific Islander ☐ Other:	Gender ☐ Female ☐ Male ☐ Other	Height feet' inches"	Weight lbs / kg
Identifying Features: ☐ Scars ☐ Moles ☐ Birthmarks ☐ Tattoos ☐ Braces ☐ Missing Teeth ☐ Glasses ☐ Other		Items worn by or with patient when found: ☐ Pants/Shorts ☐ Shirt ☐ Dress/Skirt ☐ Shoes/Socks ☐ Outerwear ☐ Jewelry ☐ Medical Devices ☐ Other		Language: ☐ English ☐ Spanish ☐ Somali ☐ Hmong ☐ Other ☐ Non-verbal	
Describe where the patient was found (Be as specific as possible, including neighborhood/street names): 					
Arrival to Hospital					
Method: ☐ EMS ☐ Law Enforcement ☐ Private Vehicle ☐ Walk-in ☐ Other:					
☐ Accompanied ☐ Unaccompanied		Details of Arrival:			
Wristband Place on Child: ☐ Yes ☐ No		Staff Responsible for Registration (Print Name):			

PEDIATRIC PATIENT IDENTIFICATION & TRACKING FORM

Photo: Attach photo here	Patient Tracking Log	
	Facility Name: Location: Number:	Arrival Date: Departure Date:
	Remove old ID band and place here	
	Facility Name: Location: Number:	Arrival Date: Departure Date:
	Remove old ID band and place here	
	Facility Name: Location: Number:	Arrival Date: Departure Date:
	Remove old ID band and place here	
Complete if Accompanied		
Name of Person Accompanying Patient: ID Checked: ☐ Yes ☐ No ☐ Adult ☐ Child/Minor		
Relationship to Patient: ☐ Parent ☐ Guardian ☐ Sibling ☐ Aunt/Uncle/Cousin ☐ Grandparent ☐ Other:		
Parent/Guardian Location Known? ☐ Yes ☐ No ☐ Unknown ☐ Inpatient Current location:	Siblings/Other Family (Names, Age, Location): ☐ Inpatient(s)	
Proof of legal guardianship or relationship? ☐ Yes ☐ No If yes, make copy and attach to this form.	Any known orders of protection or other custody issues? ☐ No known custody/protection issues ☐ Issue(s) identified:	
Complete if Unaccompanied		
Parent/Guardian Location Known? ☐ Yes ☐ No ☐ Unknown ☐ Inpatient Current location:	Parent/Guardian Contacted? ☐ Yes ☐ No Contacted By: Date/Time:	
Reunification Plan:		
Medical History and Treatment at this Facility		
Pre-existing conditions/medical problems/previous surgeries: ☐ Yes ☐ No ☐ Unknown	Allergies: ☐ Yes ☐ NKDA ☐ Unknown	
Medications: ☐ None ☐ Unknown	Treatment Received: ☐ Yes ☐ No	
Current Patient Location (be specific as room/bed or location): ☐ Admitted as in-patient ☐ Emergency Department ☐ Pediatric Safe Area		

PEDIATRIC PATIENT IDENTIFICATION & TRACKING FORM

Disposition	
☐ Child Transferred to another facility/agency (Facility Name):	
Address:	Phone:
Contact:	Transport Agency:
☐ Child Released To (Full Name):	
Known to Child: ☐ Yes ☐ No	
Relationship to Patient: ☐ Parent ☐ Guardian ☐ Sibling ☐ Aunt/Uncle/Cousin ☐ Grandparent ☐ Other:	
Picture Identification: ☐ Driver's License ☐ Passport ☐ Work/School ID ☐ Other:	
Address on ID:	Consent obtained from parent/guardian if released to another adult: ☐ Yes ☐ No (explain):
Signature of Individual Assuming Responsibility for Child (Sign, Date, Time):	
☐ Staff Responsible for Child Transfer/Release (Sign, Date, Time):	