RESPONSE TOOL

Date: _____

DEPARTMENT OF HEALTH

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	**Hair Color**	**Race**	**Gender**	**Height**	**Weight**
☐ Brown ☐ Blue ☐ Green ☐ Gray	☐ Brown ☐ Blond ☐ Black ☐ Red ☐ Other:	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Caucasian/White ☐ Hawaiian Native & Pacific Islander ☐ Other:	☐ Female ☐ Male ☐ Other	feet' inches"	lbs / kg

Identifying Features:	**Items worn by or with patient when found:**	**Language:**
☐ Scars ☐ Moles ☐ Birthmarks ☐ Tattoos ☐ Braces ☐ Missing Teeth ☐ Glasses ☐ Other	☐ Pants/Shorts ☐ Shirt ☐ Dress/Skirt ☐ Shoes/Socks ☐ Outerwear ☐ Jewelry ☐ Medical Devices ☐ Other	☐ 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)**:**

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

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)**:**