

Missing Child Intake Report

Complete the form, save it on your PC and then attach it to an email and send to: missingpersons@dcjs.ny.gov or fax to 518-457-6965.

Person Completing Form:

Last Name First Name Relationship
Phone E-mail Agency (if applicable)

Legal Guardian of Child:

Last Name First Name Relationship
Street Address City State Zip Code
Cell Phone Home Phone Work Phone E-mail

Missing Child Information:

Under which circumstance do you believe the child is missing:

Last Name First Name MI: Age: DOB Sex
Race Hgt (ft) (in.) Wgt (lbs) Hair Eyes
Place of Birth City State Mother's Maiden Name (First, Last)
School Attended Grade Social Security # Fingerprints Available
E-mail Cell Phone Cell Phone Provider

Scars, Tattoos, Piercings

Social Media: Include sites, user names and URL

Last Known Address Street City State Zip Code

Location Last Seen Date Time AM PM

Clothing Description:

Is child on the autism spectrum? Yes No Access to money/credit cards? Yes No

Suicidal Ideation Yes No If yes, explain

Concerns the child may be targeted or sexually exploited while missing? Yes No

If yes, explain

Circumstances which occurred prior to and at the time disappearance. If known, include the motivation for leaving.

Has child ever indicated the he or she would leave? Yes No Has he or she ever been missing before? Yes No

If yes, provide details (e.g., when, where, length of time missing, location while missing.)

Places where the child lived in the past (e.g., name of municipality, state and street address.)

Places (e.g., states, cities) that the child has expressed and interest in visiting or living.

Do you believe that there is any possibility that any family members, friends or others are providing aid to the child? Yes No

Identify possibilities by name and location.

Type of employment last held by the child and the employer's name and address.

Child's prior encounters with law enforcement and the courts. Describe circumstances, locations and approximate dates.

Medical, Mental Health Problems/Medications

Drug, alcohol or other chemical dependencies the child may have.

Regional, foreign accent or language other than English:

Relationship between the child's parents (e.g., adversarial/amicable/violent?

Was there an ongoing or pending custody dispute? Yes No

If yes, provide details.

Companion Information:

Last Name First Name MI: Alias/Nickname

Last Known Address City State Zip Code

Age: DOB Sex Race Hgt (ft) (in.) Wgt (lbs)

Hair Eyes Scars, Tattoos, Piercings

Social Security # Occupation Employer E-mail

Home Phone Work Phone Cell Phone Cell Phone Provider

Social Media:
Include sites, user names, URL

Location Last Seen Date Time AM PM

Medical, Mental Health Problems/Medications

Investigating Law Enforcement Agency Information:

Investigating Police Agency Investigating Officer's Name

E-mail Telephone Cell Phone

Agency Case # Report Date Other

Additional Narrative Information:

The undersigned parent/guardian or spouse (if married student) of *(Print Name of Child/Student)* hereby requests the information pertinent to the disappearance of the above named child/college student and deemed appropriate for release by the law enforcement agency responsible for the investigation of the said disappearance be published and/or circulated by any method subscribed to by the New York State Division of Criminal Justice Services (DCJS), including the use of photographs. I understand this information will be made available to the public, media, other law enforcement agencies, hospitals, social service agencies, shelters, medical examiners and/or other agencies or organizations involved with missing persons. I understand and agree that any or all information supplied by me shall be truthful and I agree to hold harmless any agency or department using, transmitting, or distributing this information for errors or omissions or commissions occasioned by information I supply. I further agree that a photocopy of this authorization shall have the same effect as the original. If available, DCJS can store and upload his/her fingerprints to the Statewide Automated Fingerprint Identification System to assist with developing lead information.

I authorize do not authorize Parent/Guardian Signature